

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

00398

Reg. Dist. No. 74

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll  
County

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 29 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 4 months, 29 days

3. (a) FULL NAME

Walter Rice Abrecht

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

Margaret E. Abrecht

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age years

Oct. 12, 1903

8. AGE: Years Months Days If less than one day

41 2 20 hrs. min.

9. Birthplace: Maryland

(Town, county, and state)

10. Usual occupation: Paperhanger and painter

11. Industry or business

FATHER 12. Name: Niles Abrecht

MOTHER 13. Birthplace: Md.

14. Maiden name: Josephine?

Md.

16. Informant: Records of Springfield State

Address: Hospital, Sykesville, Md.

17. Burial Date thereof: 1-4-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or columbarium: Lewistown meth. Cemetery

Location: Lewistown - Md.

18. Funeral director: C. E. Cline and Son

Address: Frederick - Md.

19. Date rec'd by registrar: Jan. 5 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Seventh Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 3 1944 to Jan. 2 1945

and that I last saw him alive on Jan 1 1945

Immediate cause of death

General Paroxysm

Due to

Due to

Other conditions

Psychotic syphilitic meningoencephalitis

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edward J. Kerman

M. D. mother

Address: Sykesville, Md.

Date signed: 1-2-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-42

## CERTIFICATE OF DEATH

00309

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Rural Oklahoma (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Catherine Amelia Alexander

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. W. Widowed

6. (b) Name of husband or wife: John Theodore Alexander

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Sept. 24, 1849

8. AGE:

Years

Months

Days

If less than one day

95 3 19 hrs. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER

12. Name: Charles Bell

FATHER

13. Birthplace: York -

MOTHER

14. Maiden name: Luanna Ward

FATHER

15. Birthplace: Md.

MOTHER

16. Informant: Mrs. Vivian C. Leatherwood

Address

Sykesville, Md.

17. Burial: Cemetery or crematory: Woods Chapel Cemetery Date thereof: Jan. 15, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)

Location: Liberty road, Belts Co., Md.

18. Funeral director: C. Harry Eileen

Address: Sykesville, Md.

19. Jan. 13, 1945 C. Harry Eileen (Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md.

County: Carroll

City or town: Sykesville Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Jan. 12, 1945, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to Jan. 12, 1945

and that I last saw her alive on Jan. 11, 1945

Immediate cause of death

Cardio-vascular Dis.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

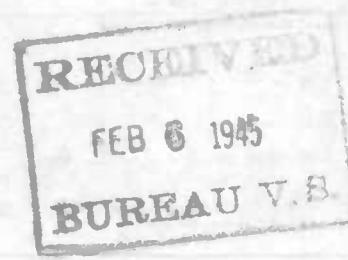
Injured at work?

## 23. SIGNATURE

Tom. E. Martin

M. D. or other

Address: Pundalltowns Md. Date signed: 1/13/45



## STATE OF MARYLAND—CERTIFICATE OF DEATH

71

## 1. PLACE OF DEATH

County Carroll  
Village or City Westminster

Registration Dist. No. 74

Length of residence in city or town where death occurred yrs. mos. 1 d. How long in U.S. if of foreign birth? yrs. mos. d.

## 2. FULL NAME Baby Ray Baker

If U.S. Veteran specify WAR

(a) Residence: No. 112 W. Westminster St., Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE Years Months Days  
1 yr 0 mo 0 d11 LESS than  
1 day, 1 hrs.  
or min.

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)  
(State or country)

13. NAME Stanley Baker

14. BIRTHPLACE (city or town)  
(State or country)

15. MAIDEN NAME Melvina

16. BIRTHPLACE (city or town)  
(State or country)

17. INFORMANT Stanley Baker

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place Home place Date Jan 24, 1945

19. UNDERTAKER C. O. Fins &amp; Son

(Address) Taneytown Md.

20. FILED Jan 24, 1945 Margaret P. Englar

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

January 23, 1945  
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from

Jan 23, 1945, to Jan 23, 1945; death is said  
to have occurred on the date stated above, at 3:00 P.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:

Cremation

Date of onset

Other Contributory Causes of importance

Coughing  
Labor

Date of

Name of operation

Was there an autopsy?

What test confirmed diagnosis?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. E. Baker, M.D.  
(Address) Westminster, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

## Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	Date of onset
	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

00311

Reg. Dist. No.

70

## 1. PLACE OF DEATH:

County BaltimoreCity or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

L. Edna Baumgardner4. Sex F.5. Color or race W.6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Andrew J. Baumgardner7. Birth date of  
Deceased (mo., day, yr.)June 12, 1880

6. (c) If alive, give age

years

8. AGE:

Years 64Months 7Days 3

If less than one day

hrs.

min.

9. Birthplace me

(Town, county, and state)

10. Usual occupation Housework11. Industry or business Wilson Wards12. Name Matilda E. Stonesifer13. Birthplace me14. Maiden name Matilda E. Stonesifer15. Birthplace me16. Informant Edwin E. WardsAddress Taneytown17. Burial BuriedDate thereof June 18, 1945

(month) (day) (year)

Cemetery or crematory ReservoirLocation Taneytown18. Funeral director Edwin E. WardsAddress Taneytown19. Date rec'd by registrar Jan 17, 1945Ethel M. McNamee  
Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Taneytown Rural

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

Prior toJanuary 15, 1945, at 1:00 P.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19and that I last saw him alive on 19

Immediate cause of death

Cerebral hemorrhage

DURATION

Due to Hypertension arteriosclerosisC-V diseaseDue to meOther conditions me

(Include pregnancy within 3 months of death)

Major findings of operations meDate of op. meAutopsy results me

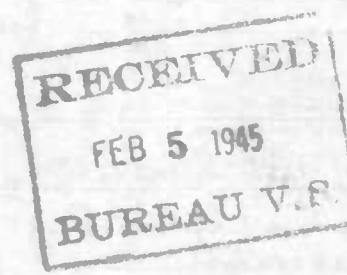
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide me Date of meWhere did injury occur? me (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury meInjured at work? me23. SIGNATURE James F. Marsh, Deputy Medical ExaminerV. D. or other meAddress New Windsor Date signed 1/15/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of date of birth is shown on

FILM No. G 92 MAR 7 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

00312

82

Reg. Dist. No.

## CERTIFICATE OF DEATH

### 1. PLACE OF DEATH

County

Carroll

City or town

Rural - Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Geraldine Bennett

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Sept. 16, 1944

8. AGE:

Years

Months

Days

If less than one day

4 3.7

hrs. min.

9. Birthplace (Town, county, and state)

Carroll Co. Maryland

10. Usual occupation

None

11. Industry or business

FATHER

James Bennett

MOTHER

MARYLAND

13. Birthplace

Beatrice Anderson

14. Maiden name

MARYLAND

15. Birthplace

MR. James Bennett

16. Informant

Address

Mt. Airy, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or cemetery

Location

NEAR Mt. Airy, Carroll Co. Md.

18. Funeral director

Address

C. W. Wall

Wifred, Md.

19. Date rec'd by registrar

Jan 20 1945

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Rural - Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.

R.D. Mt. Airy, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH

January 19 1945 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 17 1945 to Jan 19 1945

and that I last saw her alive on Jan 17, 1945

Immediate cause of death

Broncho-pneumonia

DURATION

7 days

Due to

Acute bronchitis

2 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

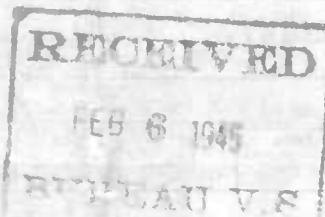
23. SIGNATURE Ernest P. Roof, M.D.

M. D. or other

Address New Market, Md. Date signed Jan 19, 1945

614880 TRUSTEESHIP OF THE PACIFIC

1945 POSTAGE PAID



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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

00313

## CERTIFICATE OF DEATH

Reg. Dlat. No. 74

1. PLACE OF DEATH:  
County..... Carroll  
City or town..... Henryton, Md. (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 2 months, 6 days  
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.  
How long in hospital or Institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Anne Arundel  
City or town..... Saverna Park (If outside city or town limits, write RURAL and give nearest town)  
Street No. .....  
(If rural, give LOCATION) ✓

## 3. (a) FULL NAME

MAMIE JEFFRIES BETTON

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) ..... March 2, 1906  
8. AGE: Years Months Days If less than one day

38	10	3	hrs.	min.
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9. Birthplace..... Earleigh Heights, Md. (Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business

12. Name..... Louis Jeffries

13. Birthplace..... North Carolina

14. Maiden name..... Anna Jones

15. Birthplace..... North Carolina

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial ..... Date thereof..... 1/8/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Earleigh Heights

Location..... Earleigh Heights Md.

18. Funeral director..... The Pick

Address..... 45 Northwest Anne Arundel

19. Jan. 5, 1945 Albert R. Surratt  
(Date rec'd by registrar) Deputy Local Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 5, 1945 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30, 1944 to Jan. 5, 1945 and that I last saw her alive on January 5, 1945.

Immediate cause of death..... Pulmonary Tuberculosis  
DURATION Nov. 1942

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 8 months of death)

Major findings or operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

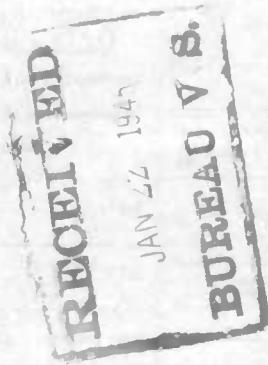
Injured at home, farm, Industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D. M. D. or other

Address..... Henryton, Md. Date signed..... 1-5-45

VS A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-2

## CERTIFICATE OF DEATH

00314

Reg. Dist. No. 24

## 1. PLACE OF DEATH:

County CarrollCity or town Marietta

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Blinley

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWSingle

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

74122

hrs. .... min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

Gottlieb Blinley

13. Birthplace.....

Russia

14. Maiden name.....

Louise — ?

15. Birthplace.....

Russia

16. Informant.....

Mrs. Louise Cadden

Address

1514 E. Fort Ave., Baltimore

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Springfield Cemetery

Location.....

Sykesville, Md.

18. Funeral director.....

W. Harry Glew

Address.....

Sykesville, Md.

19. Date.....

1945

20. Usual residence (home) of deceased:

(For newborn infants give residence of mother)

State Md.County CarrollCity or town Marietta

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1945 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1942 to January 1945and that I last saw deceased alive on January 1, 1945

Immediate cause of death.....

Cardio-vascular Disease

DURATION

Due to Arteriosclerosis

Due to.....

Other conditions Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

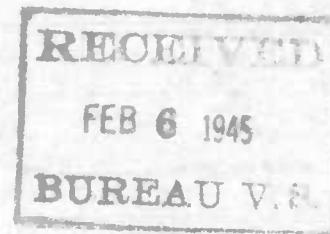
Means of injury.....

Injured at work?

23. SIGNATURE Tom. E. Martin

M. D. or other

Address RandallstownDate signed 1/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

00315

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll  
 City or town Hickling (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Carrie Etta Bond4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 8-1885 6. (c) If alive, give age years8. AGE: Years 59 Months 7 Days 15- If less than one day hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation None11. Industry or business "12. Name Benjamin H. Bond13. Birthplace Maryland14. Maiden name Emma J. Roop15. Birthplace Maryland16. Informant Benjamin BondAddress Hickling Md17. Burial Burial Date thereof June 26/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ExcavLocation Carroll Co Md18. Funeral director Edo C. TiptonAddress Hampstead Md19. (Date rec'd by registrar) 1945 1-23-45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Hickling - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1945 at 9:30 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 22 1945 to Jan. 22 1945 and that I last saw her alive on Jan. 21 1945

Immediate cause of death

Auto - ruptus

DURATION

1 moDue to Multiple Sclerosis10 years

Due to

Fracture of 7th rib4 mo.Accidental fall, slipped on wet porch.(Include pregnancy within months of death) 6 mo.

Major findings of operations

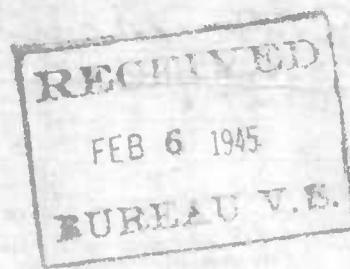
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of October 20, 1944Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury Accidental fall Injured at work?23. SIGNATURE Maurice C. Partinfield M. D. or otherAddress Hampstead Md Date signed 1-23-45





MARGIN RESERVED FOR BINDING

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 234

00316

79

Reg. Diat. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: <u>Carroll</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
County.....		State..... <u>Md.</u> County..... <u>Carroll</u>		
City or town..... <u>Rural, near Key-mars.</u>		City or town..... <u>Rural</u>		
(If outside city of town limits, write RURAL and give nearest town)		(If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death? <u>11 yrs.</u>		Street No. <u>near Key-mars.</u>		
Hospital, Institution, or street address where death occurred:		(If rural, give LOCATION)		
How long in hospital or Institution?		2. (a) If veteran, name war		
3. (a) FULL NAME <u>Emily Jane Bowers.</u>		3. (b) Social Security Number <u>none</u>		
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>	MEDICAL CERTIFICATION	
B. (b) Name of husband or wife.....		20. DATE OF DEATH <u>Jan. 25 - 1945</u>		6 p.m.
7. Birth date of deceased (mo., day, yr.) <u>1859 - Nov. 23 - 1945</u>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Jan. 25 - 1945</u> to <u>Jan. 26 - 1945</u> and that I last saw her alive on <u>Jan. 24 - 1945</u> .		DURATION <u>2 days</u>
8. AGE: Years <u>85</u>	Months <u>1</u>	Days <u>2</u>	If less than one day hrs. _____ min. _____	
9. Birthplace <u>Woodstock, Md.</u> (Town, county, and state)		Immediate cause of death <u>Heart Failure</u>		
10. Usual occupation <u>Seamstress.</u>		Due to <u>La Grippe</u>		
11. Industry or business		Due to.....		
12. Name <u>Allen J. Bowers</u>		Other conditions		
13. Birthplace <u>Md.</u>		(Include pregnancy within 3 months of death)		
14. Maiden name <u>Clementine Virginia</u>		Major findings of operations		Date of op.
15. Birthplace <u>Md.</u>		Autopsy results		
16. Informant <u>Mr. Frank Blessing</u>		PHYSICIAN: Please underlie the cause to which death should be charged statistically.		
Address <u>Key-mars, Md.</u>		22. VIOLENCE: If death was due to external causes, fill in the following:		
17. Burial <u>Burial</u> Date thereof <u>1 - 29 - 45</u> (Burial, cremation, or removal. Which?)		Accident, suicide, or homicide.....		Date of.....
Cemetery or crematory <u>Ant. Hope Cemetery</u>		Where did injury occur? (City or town) _____ (County) _____ (State) _____		
Location <u>Woodstock, Md.</u>		Injured at home, farm, industry, public place (where?) _____		
18. Funeral director <u>C. O. Faw &amp; Son</u>		Means of injury _____		Injured at work? _____
Address <u>Janeytown, Md.</u>		23. SIGNATURE <u>John H. Beall, M.D.</u>		M. D. or other _____
19. Date rec'd by registrar <u>Jan. 27 1945</u>		Address <u>Libertytown</u>		Date signed <u>1-26-45</u>
(Date rec'd by registrar)		Registrar		



M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

00317

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

## 1. PLACE OF DEATH:

County... Carroll  
 City or town... Taneytown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John Samuel Boyd

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married  
 Alice M. Short

6. (b) Name of husband or wife... Alice M. Short  
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 26, 1877

8. AGE: Years 67 Months 4 Days 18 If less than one day  
 hrs. ..... min. ....

9. Birthplace..... Maryland  
 (Town, county, and state)

10. Usual occupation. Retired Farmer

11. Industry or business

MOTHER FATHER 12. Name..... Nelson Boyd

13. Birthplace..... Maryland

14. Maiden name..... Babylon

15. Birthplace..... Maryland

16. Informant..... Mrs. Samuel Boyd

Address..... Taneytown, Md.

17. Burial..... Burial Date thereof January 17/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Taneytown Cemetery

Location..... Taneytown, Md.

18. Funeral director..... C. D. Fussell Son

Address..... Taneytown, Md.

19. Date rec'd by registrar Jan 17 1945 ETHELE M. MEHRIG  
 (Date rec'd by registrar) Local Register

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Carroll  
 City or town... Taneytown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

88219-07-8304

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

Jan 14th 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19th 1944, to Jan 14th 1945, and that I last saw him alive on Jan 13th 1945.

Immediate cause of death.....

Cerebral Hemorrhage Dec 19th 1944  
1944

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

## 23. SIGNATURE

G. M. Berner M.D. M. D. or other  
 Address..... Taneytown, Md. Date signed 1/16/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00318

## CERTIFICATE OF DEATH

74

Reg. Dist. No.

1. PLACE OF DEATH:  
 County Carroll  
 City or town Henryton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 months, 26 days  
 Hospital, Institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County   
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 917 McCulloh St.  
 (If rural, give LOCATION)

3. (a) FULL NAME  
 JOHN BREADMON

3. (b) Social Security Number  
 217-22-8730

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	single

6. (b) Name of husband or wife.....  
 6. (c) If alive, give age.....years

7. Birth date of  
 deceased (mo., day, yr.) Nov. 10, 1926

8. AGE:	Years	Months	Days	If less than one day
	18	2	15	hrs. min.

9. Birthplace St. George, S.C.  
 (Town, county, and state)

10. Usual occupation chauffeur

11. Industry or business Milton Breadmon

12. Name Milton Breadmon  
 13. Birthplace Unknown

14. Maiden name Anna Kibbets  
 15. Birthplace Unknown

16. Informant Reuben Hoffman, M.D.  
 Address Henryton, Maryland

17. Burial Burial Date thereof Jan 30 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location Annapolis Road.

18. Funeral director Adolphus Shalsead

Address 918 Druid Hill Ave

19. Jan. 25, 1945 Albert R. Swank, M.D.  
 (Date rec'd by registrar)

Deputy Local Registrar

Address Henryton, Md.

Date signed 1-25-45

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1945 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1944 to Jan. 25, 1945, and that I last saw him alive on Jan. 25, 1945.

Immediate cause of death Pulmonary Tuberculosis DURATION April 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

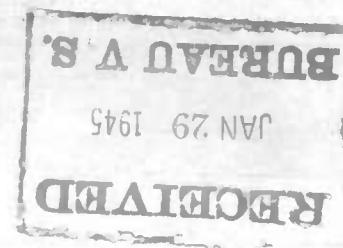
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D. M. D. or other

Address Henryton, Md. Date signed 1-25-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00319

## CERTIFICATE OF DEATH

74

Reg. Dist. No. ....

1. PLACE OF DEATH:  
County..... Carroll  
City or town..... Henryton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death..... 3 months, 28 days  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Worcester  
City or town..... Berlin, R.F.D. #3  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MAGGIE BRIDDELL

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... March 12, 1903

8. AGE: Years	Months	Days	If less than one day
41	10	3	..... hrs. ..... min.

9. Birthplace..... Berlin, Md.  
(Town, county, and state)

10. Usual occupation..... Factory Worker

11. Industry or business

12. Name	Thomas Lookwood
13. Birthplace	Unknown

14. Maiden name	Jennie Bowen
15. Birthplace	Unknown

16. Informant	Reuben Hoffman, M.D.
Address	Henryton, Maryland

17. Burial	Date thereof	Jan 15, 1945	
(Burial, cremation, or removal. Which?)	(month)	(day)	(year)

Cemetery or crematory	Evergreen Cemetery
Location	Salisbury, Md.

18. Funeral director	S. W. Chase and Son
Address	638 N. Gilmore St.

19. Jan. 15, 1945	Albert R. <i>Hoffman</i>
(Date rec'd by registrar)	Deputy Local Registrar

3. (b) Social Security Number  
219-03-2065

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 15, 1945, at 12:15 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18, 1944, to Jan. 15, 1945, and that I last saw her alive on January 15, 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

June 1944

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

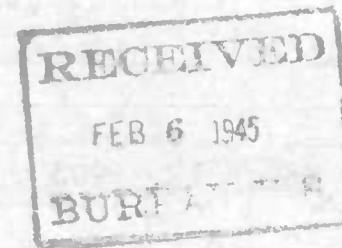
23. SIGNATURE.....

Reuben Hoffman, M.D. M. D. or other  
Henryton, Md. Date signed 1-15-45

RECEIVED BY COMMUNIST STATE OPERATOR

AMERICAN COMMUNIST

RECEIVED BY COMMUNIST



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

00320

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County CarrollCity or town Patapsco

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Matilda Brown4. Sex F5. Color or race W6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Noah Brown6.(c) If alive, give age years7. Birth date of deceased (mo., day, yr.) March

1872

8. AGE: Years 72 Months 10 Days  If less than one day  hrs.  min. 9. Birthplace Carroll Co. Md.  
(Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name William Flater13. Birthplace Md.14. Maiden name Martha Bloom15. Birthplace Md.16. Informant Marshall FlaterAddress Patapsco, Md.17. Burial Burial Date thereof Jan. 7<sup>th</sup> 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pleasant GroveLocation Sandy Point Carroll Co. Md.18. Funeral director H. Bankard & SonAddress Westminster, Md.19. (Date rec'd by registrar) 1/6/45 19. 45 & Alma Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty CarrollCity or town Patapsco

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/519. 45 at 7 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

1/3 19. 45 to 1/5 19. 45  
and that I last saw her alive on 1/5 19. 45

Immediate cause of death.....

Acute Cerebral Hemorrhage

DURATION

36 hrs.

Due to.....

Ch. Colitis - Colitis6 years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE Shirley Brown

(Mrs.)

M. D. or other Westminister Hospital Date signed 1/5/45  
Address Westminister Hospital

RECEIVED

FEB 6 1945

BUREAU V.1

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00321

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

## 1. PLACE OF DEATH:

County

Carroll

City or town

Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

14

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Ellen Carr

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

William Thomas Carr

7. Birth date of deceased (mo., day, yr.)

Feb 14 - 1875

(b) If alive, give age

years

8. AGE:

69

Years

11

Months

5

Days

If less than one day

hrs.

min.

9. Birthplace

Carroll Co.

Md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

12. Name

Sarah Carr

13. Birthplace

Maryland

Maryland

14. Maiden name

Catherine Smith

Smith

15. Birthplace

Maryland

Maryland

16. Informant

Mary E. White

Westminster, Md.

Address

Westminster, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 22-1945

(month) (day) (year)

Cemetery or crematory

Wafeldsbury Cemetery

Location

Wafeldsbury Md.

18. Funeral director

A. B. Arkard &amp; Son

Address

Westminster, Md.

19. Date rec'd by registrar

1/30/46

19

R. W. Woodward

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1010

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 19 1945 at 3-30

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 30 1941 to 1-18-1945 and that I last saw her alive on Jan 18 1845

Immediate cause of death

Cerebral hemorrhage 5 days

Due to

arteriosclerosis indi-  
nated

Due to

Myocarditis 4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Roosevelt Hospital

Westminster

1/19/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00322

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

74

1. PLACE OF DEATH  
 County.....Carroll  
 City or town.....Henryton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....2 months, 30 days  
 Hospital, institution, or street address where death occurred:  
 Maryland Tuberculosis Sanatorium  
 Colored Branch, Henryton, Md.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State.....Maryland County.....Howard  
 City or town.....Laurel  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

JAMES WESLEY COATES

## 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife.....Venie Coates.....

7. Birth date of deceased (mo., day, yr.).....August 15, 1871.....(c) If alive, give age 72 years

8. AGE: Years	Months	Days	If less than one day
73	5	7	hrs. .... min.

9. Birthplace.....Lower Marlboro, Md. ....  
 (Town, county, and state)

10. Usual occupation.....Farm Laborer

11. Industry or business

12. Name.....Isaac Coates

13. Birthplace.....Lower Marlboro, Md.

14. Maiden name.....Mandie Johnson

15. Birthplace.....Lower Marlboro, Md.

16. Informant.....Reuben Hoffman, M.D.

Address.....Henryton, Maryland

17. (Burial, cremation, or removal. Which?).....Burial.....Date thereof.....1/24/45  
 (month) (day) (year)

Cemetery or crematory.....Bacon Cemetery

Location.....Bacon near Laurel, Md.

18. Funeral director.....Ridgley Lelby

Address.....Laurel and

19. Jan. 22 1945 Albert R. Swank  
 (Date rec'd by registrar) Deputy Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 22, 1945, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 October 23, 1944, to Jan. 22, 1945,  
 and that I last saw h. im alive on Jan. 22, 1945.

Immediate cause of death.....Pulmonary Tuberculosis DURATION 8-1-44

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

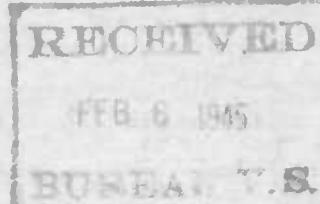
Means of injury.....

Injured at work?

23. SIGNATURE.....Reuben Hoffman, M.D.

M. D. or other

Address.....Henryton, Md. Date signed 1-22-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13-20

00323

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

## 1. PLACE OF DEATH:

Carroll

County

Sykesville, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State

Baltimore City

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

917 St. Charles Avenue

Street No.

(If rural, give LOCATION)

## 3. (a) FULL NAME

Verna Magdaline Collins

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Charles Collins

7. Birth date of deceased (mo., day, yr.) Deceased Nov. 28, 1905

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

39 1 10 hrs. min.

9. Birthplace Hagerstown, Maryland - Washington (Town, county, and state) county

10. Usual occupation Housewife

## 11. Industry or business

12. Name Wm. Lewis Willman

13. Birthplace Hagerstown, Maryland

14. Maiden name Clara May Carbaugh

15. Birthplace Hagerstown, Maryland

Miss Belva Willman

16. Informant Mrs. Pauline Elliott, sisters

Address 917 St. Charles Street

Baltimore, Maryland

## 17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof 1-12-45

(month) (day) (year)

Cemetery or crematory United Brethren

Location Thurmont Maryland

18. Funeral director Harry A. Witke

Address 4101 Edmondson Ave.

19. (Date record by registrar) 19 85

R. W. Kedwell  
per D.M.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State

Baltimore City

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

917 St. Charles Avenue

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1945, at 7:40a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec. 16, 1944, to Jan. 8, 1945, and that I last saw her alive on Jan. 7, 1945.

Immediate cause of death

Emphysema (left side)

Due to Perforated Lung abscess

DURATION

unk

unk

unk

Other conditions Chronic Interstitial Nephritis 6 yrs.

Toxic Psychoosis (endogenous) 2 mos.

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edward J. Kerman

M. D. or other

Address 27 Keswick, Md. Date signed 1-8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 924

00324

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

## 1. PLACE OF DEATH: Carroll Co.

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mattie L. Colson

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

Oliver Colson

7. Birth date of

deceased (mo., day, yr.)

JAN. 26, 1883

6. (c) If alive, give age

years

8. AGE:

Years  
61Months  
11Days  
7If less than one day  
hrs. .... min.

9. Birthplace.....

Carroll Co. Md

(Town, county, and state)

10. Usual occupation.....

Housework

11. Industry or business

FATHER

12. Name.....

Joseph F. Fisher

13. Birthplace.....

Maryland

MOTHER

14. Maiden name.....

Tina J. Evans

15. Birthplace.....

Maryland

16. Informant.....

Mrs. Berrie M. Shugart

Address.....

R. D. Sykesville, Md

17. Burial

(Burial, cremation, or removal, where?)

Date thereof.....

1-6-45

(month) (day) (year)

Cemetery or crematory.....

Morgan Chapel

Location.....

Day, Carroll Co. Md.

18. Funeral director.....

Address.....

Winfield, Md.

19. (Date rec'd by registrar)

1945

(Date signed)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Carroll

City or town.....

Florence

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

R. D. Sykesville

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

JAN. 3, 1945, st. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 20, 1944, to Jan. 3, 1945

and that I last saw her alive on Jan. 3, 1945

Immediate cause of death.....

Ch. Ventr. Heart Disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE

Address.....

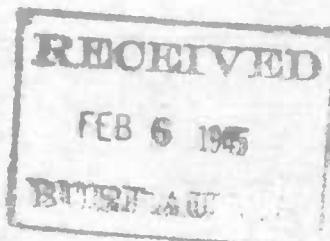
Randallstown

Md.

M. D. or other

Date signed

1/4/45



## MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for change of  
year of birth 1910 **STATE OF MARYLAND—CERTIFICATE OF DEATH****1. PLACE OF DEATH**County CarrollVillage or City New WindsorLength of residence in city or town where death occurred 20 yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

93rd

00325  
50

Registration Dist. No.

St. 0 Ward 0**2. FULL NAME** Louise P. (Zeph) Cook

(a) Residence: No.

(Usual place of abode)

If U. S. Veteran, specify WAR

St. 0 Ward 0

If nonresident give city or town and State

**PERSONAL AND STATISTICAL PARTICULARS****3. SEX**F**4. COLOR OR RACE**W**5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word)Widowed

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofJohn W. Cook**6. DATE OF BIRTH** (month, day, and year)August 9-1869**7. AGE**Years  
75Months  
0Days  
0If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.**OCCUPATION**8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BODKEEPER, etc.None9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation**12. BIRTHPLACE** (city or town)  
(State or country)Carroll Co. Md.**MOTHER FATHER**13. NAME George W. Zeph14. BIRTHPLACE (city or town)  
(State or country)Carroll Co. Md.

15. MAIDEN NAME

Josephine Barnes16. BIRTHPLACE (city or town)  
(State or country)Carroll Co. Md.

17. INFORMANT

Mrs. Charles Bankard

(Address)

New Windsor, Md.

18. BURIAL, CREMATION, OR REMOVAL

Burial in cemeteryPlace New Windsor, Md.Date Jan. 12

1945

19. UNDERTAKER

Bankard & Son

(Address)

Westminster, Md.

20. FILED

Jan. 12, 1945

Date

1945

Registrar.

**MEDICAL CERTIFICATE OF DEATH****21. DATE OF DEATH**January 10  
(Month)  
(Day), 1945  
(Year)

22. I HEREBY CERTIFY. That I attended deceased from

I last saw him alive on Jan. 9, 1945; death is saidto have occurred on the date stated above, et 10 a.m.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Arteriosclerotic P.-V. diseaseDate of onset  
4

Other Contributory Causes of Importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What last confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of Injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) James J. Monk M. D.(Address) Westminster, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Date of onset

1915

Chronic interstitial nephritis

Date of onset

1921

Cerebral hemorrhage

Date of onset

July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy

Date of onset

1 week ago

Run over by street car

1 week ago

Peritonitis

3 days ago

Other contributory causes of importance:

Gallstones

Date of onset

May 1, 1923

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

00326

## CERTIFICATE OF DEATH

Reg. Dist. No. 75

## 1. PLACE OF DEATH:

County... Carroll  
City or town... Alexia

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

George E Ehrhardt

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWMarried

B. (5) Name of husband or wife

Lizzie A Ehrhardt6. (c) If alive, give age 67 years

7. Birth date of

deceased (mo., day, yr.)

Sept 23 - 1875

8. AGE:

Years

Months

Days

If less than one day

69311

....hrs. ....min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Farmers

11. Industry or business

Samuel Ehrhardt

MOTHER FATHER

12. Name

Samuel Ehrhardt

13. Birthplace

Md

14. Maiden name

Hettie Wadewau

15. Birthplace

Md

16. Informant

Elmer Ehrhardt

Address

Alexia Md

17. Burial

Date thereof Jan 7/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Stilts

Location

YORK CO - Pa.

18. Funeral director

Edw A Tipton

Address

Hanover Rd

19. Date rec'd by registrar

Jan. 6 1945

(date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... CarrollCity or town... Alexia (If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 4 1945 at 4 P M21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 12 1944 to January 4 1945 and that I last saw him alive on January 4 1945

Immediate cause of death.....

By pulmonary cardio - renal ?Due to Vascular DiseaseDue to Obstructive nephritis ?

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

—

Date of

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

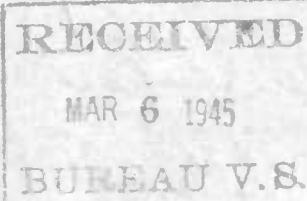
Injured at work?

23. SIGNATURE

Jacob E Bush M.D.

M. D. or other

Address Marshall Rd Date signed Jan 7/45



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2327

## CERTIFICATE OF DEATH

00327

Reg. Dist. No. 70

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

## 11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Pleasant Valley

Location

Pleasant Valley

18. Funeral director

Address

Dunetown, Md.

19. Date rec'd by registrar

19. 45

Ethel M. Mehling

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 12th 1945, 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 11th 1945 to Jan 12th 1945 and that I last saw her alive on Jan 12th 1945.

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 1/2 hr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. B. Bemmer, M.D.

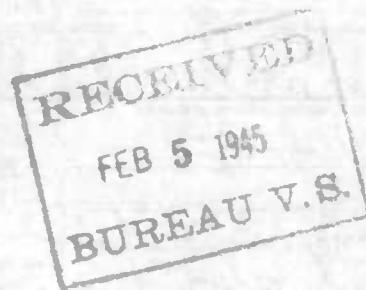
M. D. or other

Address

Dunetown, Md.

Date signed

1/13/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

00328

## CERTIFICATE OF DEATH

Reg. Dist. No. 70

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County Carroll  
 City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME  
Sarah R. Gringer

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Calvin T. Gringer

7. Birth date of deceased (mo., day, yr.) June 18, 1865 6. (c) If alive, give age years

8. AGE: Years 79 Months 7 Days 11 If less than one day  
 hrs.  min.

9. Birthplace Carroll County, Md.  
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name David Panebaker  
 MOTHER FATHER

13. Birthplace Maryland  
 MOTHER FATHER

14. Maiden name Hannah Bixler  
 MOTHER FATHER

15. Birthplace Maryland  
 MOTHER FATHER

16. Informant Dr. C. M. Blumer  
 Address Taneytown, Md.

17. Burial Burial Date thereof 2-1-45  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Reformed Cemetery  
 Location Taneytown, Md.

18. Funeral director 10 Funeral Home  
 Address Taneytown, Md.

19. Date rec'd by registrar Jan 31, 1945 Ethele M. Melvin  
 Registrar Local

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Taneytown (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29th 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25th 1945, to Jan 29th 1945, and that I last saw her alive on Jan 29th 1945.

Immediate cause of death Cerebral Hemorrhage DURATION 4 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

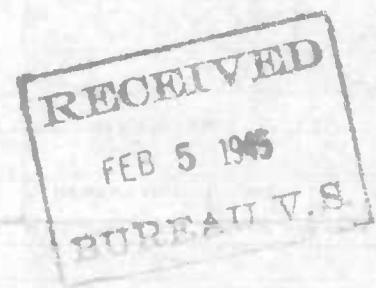
Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE G. M. Berner, M.D. M. D. or other

Address Taneytown, Md. Date signed 1/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00329

74

Reg. Dist. No. ....

1. PLACE OF DEATH: Carroll  
County.....  
City or town..... Henryton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 months, 23 days  
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium  
colored Branch, Henryton, Md.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....  
City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 209 N. Gilmore St.  
(If rural, give LOCATION)

2.(a) If veteran, name war. 

## 3. (a) FULL NAME

ALBERT GLADDEN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
male	colored	married		
6.(b) Name of husband or wife..... Ella Gladden				
6.(c) If alive, give age..... years				
7. Birth date of deceased (mo., day, yr.) Oct. 22, 1910				
8. AGE: Years Months Days If less than one day				
34 2 19 hrs. min.				

9. Birthplace..... Baltimore, Md.  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business  
12. Name..... Alfred Gladden  
13. Birthplace..... Maryland

14. Maiden name..... Victoria Brooks  
15. Birthplace..... Virginia

16. Informant..... Reuben Hoffman, M.D.  
Address..... Henryton, Maryland

17. Burial  
(Burial, cremation, or removal. Which?) Date thereof..... Jan. 10, 1945  
(month) (day) (year)

Cemetery or crematory..... Mt. Auburn Cem  
Location..... Landlawn.

18. Funeral director..... Katie Williams  
Address..... 322 N. Schrodeler St.

19. Jan. 10, 1945 Albert R. Schrodeler  
(Date rec'd by registrar) Deputy Local Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 10, 1945 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 1944, to Jan. 10, 1945 and that I last saw him alive on January 10, 1945.

Immediate cause of death..... Pulmonary Tuberculosis  
DURATION Jan. 12 1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

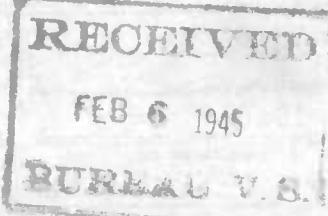
Means of injury

Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.  
M. D. or other  
Address..... Henryton, Md. Date signed..... 1-10-45

RELATED TO TWENTIETH STATE CHARTER

STATE OF GEORGIA



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5

## CERTIFICATE OF DEATH

00330

83

Reg. Dist. No.

1. PLACE OF DEATH: Carroll  
 County Woodbine  
 City or town Woodbine  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? life  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Carroll  
 City or town Woodbine  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

## 3. (a) FULL NAME

Samuel S. Gosnell

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Gladys E. Gosnell  
 7. Birth date of deceased (mo., day, yr.) JAN. 25, 1868 8. (c) If alive, give age 57 years  
 8. AGE: Years 76 Months 11 Days 20 If less than one day hrs. . . . . min.  
 8. Birthplace Frederick Co. Maryland  
 (Town, county, and state)  
 10. Usual occupation Electrician (Retired)  
 11. Industry or business  
 12. Name Francis W. Gosnell  
 13. Birthplace MARYLAND  
 14. Maiden name MARY HUGENBERG  
 15. Birthplace MARYLAND  
 18. Informant Mrs. Gladys F. Gosnell  
 Address Woodbine, Md.  
 17. Burial Burial Date thereof 1-17-45  
 (Burial, cremation, or removal. Which?) Date (month) (day) (year)  
 Cemetery or crematory Maryland Chapel  
 Location Day, Carroll Co. Md.  
 18. Funeral director G.W. Walls  
 Address Wright Ave  
 19. Date rec'd by registrar Jan 17 1845 Registrar William Glennan

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 15, 1945 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 to Jan 14 1945 and that I last saw him Jan 13 1945 alive on Jan 13 1945

Immediate cause of death carcinoma of prostate DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

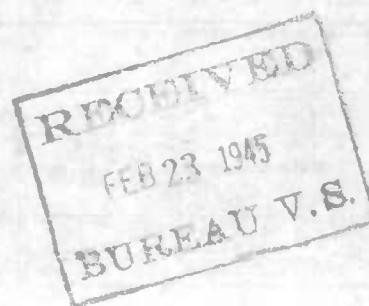
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John Barnes MD M. D. or other \_\_\_\_\_Address Syrkenside Date signed Jan 15 1945



M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

00331

## CERTIFICATE OF DEATH

Reg. Dist. No. 71

## 1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Universitytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 90 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mrs. Dannie Haines

4. Sex

g

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widow

B. (b) Name of husband or wife.....

Jonathan Haines

7. Birth date of deceased (mo., day, yr.)

JAN 9, 1853

B. (c) If alive, give age..... years

8. AGE:

Years  
91Months  
2Days  
9

11 less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

me

10. Usual occupation.....

Housework

11. Industry or business.....

Alvarez Stultz

12. Name.....

John

13. Birthplace.....

Unknown

14. Maiden name.....

Unknown

15. Birthplace.....

Le Roy

16. Informant.....

Dannie Haines

Address.....

Universitytown, Md

17. Burial.....

Burial

Date thereof..... (month) (day) (year)

(Burial, cremation, or removal. Which)

Cemetery or crematory.....

Bw of God

Location.....

Universitytown, Md

18. Funeral director.....

Ed. Russ Son

Address.....

Danetown, Md.

19. Date rec'd by registrar

Margaret R. Englar

Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 18, 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1, 1945, to Jan 18, 1945,

and that I last saw h. ev. alive on Jan 18, 1945.

Immediate cause of death.....

Hysteria

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. H. H. 9

M. D. or other

Address.....

Kleen Brown

Date signed 1-19-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

00332

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
County.....  
City or town..... Henryton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 months, 30 days  
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland  
City or town..... Baltimore  
Street No..... 520 W. Preston Street  
(If outside city or town limits, write RURAL and give nearest town)  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

DOROTHY ELIZABETH HENSON

## 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife..... Norman Henson

27

20. DATE OF DEATH January 13, 1945, at 2:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1944, to Jan. 13, 1945  
and that I last saw her alive on January 13, 1945

7. Birth date of deceased (mo., day, yr.) August 28, 1919

8. AGE: Years	Months	Days	If less than one day
25	4	16	hrs. min.

9. Birthplace..... Baltimore, Md.  
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business.....

12. Name..... Daniel Johnson

13. Birthplace..... Unknown

14. Maiden name..... Lela Williams

15. Birthplace..... Unknown

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial (Burial, cremation, or removal, which?) Date thereof (month) (day) (year)  
Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Jan. 13, 1945

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

22. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 14, 1944, to Jan. 13, 1945

and that I last saw her alive on January 13, 1945

Immediate cause of death..... Pulmonary Tuberculosis

OURATION

Oct.

1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

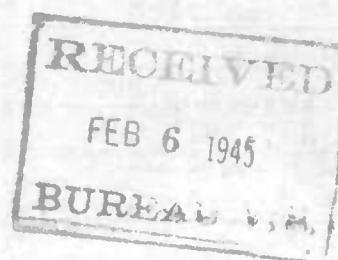
M. D. or other

Address..... Henryton, Md.

Date signed 1-13-45

RECEIVED BY AUTHORIZED STATE ATTORNEY

RECEIVED BY STAFF ATTORNEY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

00333

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Carroll

County.....  
City or town..... rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 months, 29 days

Hospital, Institution, or street address where death occurred:  
Springfield State Hospital

How long in hospital or institution?.....

3. (a) FULL NAME  
Milton George Hiss

4. Sex  
male | 5. Color or race  
white | 6. (a) Single, married, widowed, or divorced  
married

6. (b) Name of husband or wife  
Effie Walter

7. Birth date of  
deceased (mo., day, yr.) June 9, 1887  
6. (c) If alive, give age..... years

8. AGE: Years  
57 | Months  
7 | Days  
20 | If less than one day  
..... hrs. ..... min.

9. Birthplace.....  
(Town, county, and state)  
Maryland

10. Usual occupation.....  
Clerk

11. Industry or business.....  
Railroad

FATHER  
12. Name.....  
Frank Hiss

13. Birthplace.....  
Maryland

MOTHER  
14. Maiden name.....  
Nannie Hopkins

15. Birthplace.....  
Maryland

16. Informant.....  
Springfield State Hosp. records

Address.....  
Sykesville, Maryland

17. Burial.....  
(Burial, cremation, or removal. Which?)  
Date thereof..... 2-1-45  
(month) (day) (year)

Cemetery or crematory.....  
Tudor Park

Location.....  
Tudor Park

18. Funeral director.....  
James L. McCully

Address.....  
130 E. 7th Ave.

19. Date rec'd by registrar.....  
1/31 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number  
George Milton Hiss

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 29  
1945, at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 19 1944 to Jan. 29 1945  
and that I last saw him alive on January 28 1945

Immediate cause of death.....  
Cerebral hemorrhage

Due to.....  
Arteriosclerosis, prior to 1936

Due to.....

Other conditions.....  
Psychosis with cerebral arteriosclerosis  
(Include pregnancy within 8 months of death)  
5 yrs.

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE  
Robert Bertrand May, M.D.  
Springfield State Hospital M. D. or other  
Address..... Sykesville, Maryland Date signed 1-29-45

Registrar

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131-G

00334

## CERTIFICATE OF DEATH

Reg. Dist. No. 7.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 1. PLACE OF DEATH:

County.....

City or town.....

Carroll  
Westminster (Rural)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Ella Missouri Hively

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widow  
6. (b) Name of husband or wife John C. Hively

7. Birth date of deceased (mo., day, yr.)

March 3 - 1867

6. (c) If alive, give age.....years

## 8. AGE:

Years	Months	Days	If less than one day
77	10	12	hrs. min.

## 9. Birthplace

Carroll County Md.

(Town, county, up-state)

## 10. Usual occupation

Housekeeper

## 11. Industry or business

Andrew Myers

## 12. Name

Maryland

## 13. Birthplace

Mandella Myers

## 14. Maiden name

Maryland

## 15. Birthplace

Mrs. C. Farmer

## 16. Informant

Westminster Md. R. 6. 7

## Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan. 18-1945

(month) (day) (year)

## Cemetery or cemetery

Meadow Branch Cem.

## Location

Towytown Road

## 18. Funeral director

Al W. Hively &amp; Sons

## Address

Bacon Bridge &amp; New Windsor Md.

## 19. January 14 1945

(Date rec'd by registrar)

Margaret R. Engler

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....County.....

City or town.....(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15

1945 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 - 1945 to Jan 15 1945 and that I last saw her alive on Jan 14 - 1945

Immediate cause of death

Myocarditis (chr)  
Asthma (chr)

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

None

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

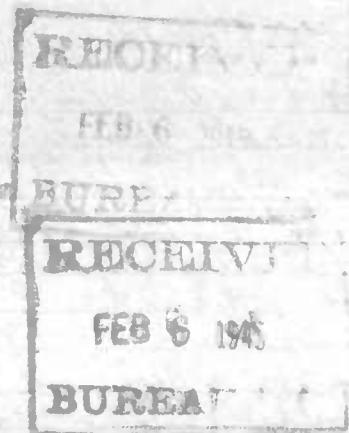
John C. Farmer

M. D. or other

Address.....Date signed..1-16-45

RECEIVED FEDERAL BUREAU OF INVESTIGATION

MAILED TO ATTACHED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *162-8*

00335

## CERTIFICATE OF DEATH

Reg. Dist. No. *74*

1. PLACE OF DEATH: **Carroll**  
 County.....  
 City or town..... **rural near Sykesville**  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **2 months, 15 days**  
 Hospital, Institution, or street address where death occurred:  
**Springfield State Hospital**  
 How long in hospital or institution? **2 months, 15 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... **Maryland** County..... **Carroll**  
 City or town..... **Manchester**  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Theodore Hoffacker**

## 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... **Eliza Warner**7. Birth date of deceased (mo., day, yr.) **April 18, 1859**

6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
85	9	23	hrs. min.

9. Birthplace..... **nr. Alesia, Carroll Co., Md.**  
(Town, county, and state)10. Usual occupation..... **farming**11. Industry or business **agriculture**12. Name..... **Jacob Hoffacker**13. Birthplace **Carroll County, Maryland**14. Maiden name..... **Susanna Markey**15. Birthplace **Baltimore County, Maryland**16. Informant **Springfield State Hosp. records**Address **Sykesville, Maryland**17. Burial Date thereof **Feb. 5 1945**  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory **Manchester Cemetery**Location **Manchester, Md.**18. Funeral director **George Fink & Son**Address **Manchester, Md.**19. Date rec'd by registrar **Feb. 3 1945**

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **January 31** **19 45** at **5:35 p.m.**21. I CERTIFY that death occurred on the date above stated: that I attended deceased from **January 11** **19 45** to **Jan. 31** **19 45** and that I last saw h..... alive on **January 31** **19 45**

Immediate cause of death.....

**Senility**

DURATION

**1 year**

Due to.....

Due to.....

Other conditions **Senile psychosis,**  
**simple deterioration**

(Include pregnancy within 3 months of death)

**1 year**

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE *Robert Bertrand May M.D.*  
 Springfield State Hospital M. D. or otherAddress **Sykesville, Maryland** Date signed **1-31-45**

RECEI

FEB 6 196

BURLIN



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00336

## CERTIFICATE OF DEATH

74

Reg. Dist. No. ....

1. PLACE OF DEATH:  
 County Carroll  
 City or town Henryton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 months, 16 days  
 Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1211 Spring Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war /

## 3. (a) FULL NAME

FAYETTE HOOD

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

B.(b) Name of husband or wife.....

B.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 26, 1903

8. AGE: Years	Months	Days	If less than one day
41	11	18	hrs. min.

9. Birthplace Lancaster, South Carolina  
 (Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name John Hood13. Birthplace Unknown14. Maiden name ? Nelson15. Birthplace Unknown16. Informant Reuben Hoffman, M.D.Address Henryton, Maryland17. Removal Date thereof 1/15/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt Calvary

Location

18. Funeral director Fredrick H. NeesleyAddress 578 W. Beale St.19. Jan. 13, 1945 Albert R. Swanklin  
 (Date rec'd by registrar) Deputy Local Registrar3. (b) Social Security Number  
220-09-4188

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1945 at 10:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1944 to Jan. 13, 1945and that I last saw him alive on Jan. 13, 1945.Immediate cause of death Pulmonary TuberculosisDURATION  
vac.  
1943

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 1-13-45

RELATING TO THE UNITED STATES GOVERNMENT

RELATING TO THE UNITED STATES

RECEIVED

FEB 6 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-2

00337

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll

County

Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs 3 mo 10 d

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 15 yrs 3 mo 10 d

## 3. (a) FULL NAME

Maud V. Hoover

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 9, 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

68

4

7

hrs.

min.

9. Birthplace Washington County, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

William H. Hoover

12. Name

13. Birthplace Washington County, Md.

MOTHER

FATHER

14. Maiden name

15. Birthplace

16. Informant

17. Burial

18. Funeral director

19. Date rec'd by registrar

Address

20. Date of death

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

22. VIOLENCE: If death was due to external causes, fill in the following:

23. SIGNATURE

24. Address

25. Date signed

26. M. D. or other

27. Date of op.

28. Autopsy results

29. PHYSICIAN: Please underline the cause to which death should be charged statistically.

30. Date of

31. (City or town)

32. (County)

33. (State)

34. Injured at home, farm, industry, public place (where?)

35. Means of injury

36. Injured at work?

37. Date signed

38. Address

39. M. D. or other

40. Date of

41. (City or town)

42. (County)

43. (State)

44. Injured at work?

45. Date of

46. Address

47. M. D. or other

48. Date of

49. Address

50. M. D. or other

51. Date of

52. Address

53. M. D. or other

54. Date of

55. Address

56. M. D. or other

57. Date of

58. Address

59. M. D. or other

60. Date of

61. Address

62. M. D. or other

63. Date of

64. Address

65. M. D. or other

66. Date of

67. Address

68. M. D. or other

69. Date of

70. Address

71. M. D. or other

72. Date of

73. Address

74. M. D. or other

75. Date of

76. Address

77. M. D. or other

78. Date of

79. Address

80. M. D. or other

81. Date of

82. Address

83. M. D. or other

84. Date of

85. Address

86. M. D. or other

87. Date of

88. Address

89. M. D. or other

90. Date of

91. Address

92. M. D. or other

93. Date of

94. Address

95. M. D. or other

96. Date of

97. Address

98. M. D. or other

99. Date of

100. Address

101. M. D. or other

102. Date of

103. Address

104. M. D. or other

105. Date of

106. Address

107. M. D. or other

108. Date of

109. Address

110. M. D. or other

111. Date of

112. Address

113. M. D. or other

114. Date of

115. Address

116. M. D. or other

117. Date of

118. Address

119. M. D. or other

120. Date of

121. Address

122. M. D. or other

123. Date of

124. Address

125. M. D. or other

126. Date of

127. Address

128. M. D. or other

129. Date of

130. Address

131. M. D. or other

132. Date of

133. Address

134. M. D. or other

135. Date of

136. Address

137. M. D. or other

138. Date of

139. Address

140. M. D. or other

141. Date of

142. Address

143. M. D. or other

144. Date of

145. Address

146. M. D. or other

147. Date of

148. Address

149. M. D. or other

150. Date of

151. Address

152. M. D. or other

153. Date of

154. Address

155. M. D. or other

156. Date of

157. Address

158. M. D. or other

159. Date of

160. Address

161. M. D. or other

162. Date of

163. Address

164. M. D. or other

165. Date of

166. Address

167. M. D. or other

168. Date of

169. Address

170. M. D. or other

171. Date of

172. Address

173. M. D. or other

174. Date of

175. Address

176. M. D. or other

177. Date of

178. Address

179. M. D. or other

180. Date of

181. Address

182. M. D. or other

183. Date of

184. Address

185. M. D. or other

186. Date of

187. Address

188. M. D. or other

189. Date of

190. Address

191. M. D. or other

192. Date of

193. Address

194. M. D. or other

195. Date of

196. Address

197. M. D. or other

198. Date of

199. Address

200. M. D. or other

201. Date of

202. Address

203. M. D. or other

204. Date of

205. Address

206. M. D. or other

207. Date of

208. Address

209. M. D. or other

210. Date of

211. Address

212. M. D. or other

213. Date of

214. Address

215. M. D. or other

216. Date of

217. Address

218. M. D. or other

219. Date of

220. Address

221. M. D. or other

222. Date of

223. Address

224. M. D. or other

225. Date of

226. Address

227. M. D. or other

228. Date of

229. Address

230. M. D. or other

231. Date of

232. Address

233. M. D. or other

234. Date of

235. Address

236. M. D. or other

237. Date of

238. Address

239. M. D. or other

240. Date of

241. Address

242. M. D. or other

243. Date of

244. Address

245. M. D. or other

246. Date of

247. Address

248. M. D. or other

249. Date of

250. Address

251. M. D. or other

252. Date of

253. Address

254. M. D. or other

255. Date of

256. Address

257. M. D. or other

258. Date of

259. Address

260. M. D. or other

261. Date of

262. Address

263. M. D. or other

264. Date of

265. Address

266. M. D. or other

267. Date of

268. Address

269. M. D. or other

270. Date of

271. Address

272. M. D. or other

273. Date of

274. Address

275. M. D. or other

276. Date of

277. Address

278. M. D. or other

279. Date of

280. Address

281. M. D. or other

282. Date of

283. Address

284. M. D. or other

285. Date of

286. Address

287. M. D. or other

288. Date of

289. Address

290. M. D. or other

291. Date of

292. Address

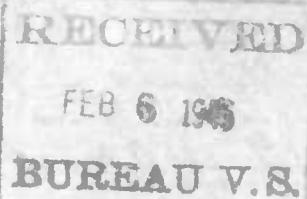
293. M. D. or other

294. Date of

295. Address

296. M. D. or other

297. Date of



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 21

## CERTIFICATE OF DEATH

00338

Reg. Dist. No. 70

1. PLACE OF DEATH: Carroll  
 County: Rural Taneytown  
 City or town: (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State: \_\_\_\_\_ County: \_\_\_\_\_  
 City or town: \_\_\_\_\_ (If outside city or town limits, write RURAL and give nearest town)  
 Street No.: \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war: \_\_\_\_\_

3. (a) FULL NAME: George Franklin Hock  
 4. Sex: M 5. Color of face: W 6. (a) Single, married, widowed, or divorced: Single  
 6. (b) Name of husband or wife: none  
 7. Birth date of deceased (mo., day, yr.): Aug 17, 1860 8. (c) If alive, give age: \_\_\_\_\_ years  
 8. AGE: Years: 84 Months: 15 Days: 0 If less than one day: \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace: md (Town, county, and state)  
 10. Usual occupation: farmer  
 11. Industry or business: William Hock  
 12. Name: William Hock  
 13. Birthplace: md  
 14. Maiden name: Ellen Burllinger  
 15. Birthplace: md  
 16. Informant: William M. Hock  
 Address: Taneytown R.D.  
 17. Burial: Burial Date thereof: Jan 20, 1945  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory: St. Joseph's  
 Location: Taneytown, md  
 18. Funeral director: Levy Dressler  
 Address: Taneytown, md  
 19. Date rec'd by registrar: Jan 18 1945 19. Date of death: Jan 18 1945  
 (Date rec'd by registrar) (Date of death) Ethel M. Hock Local Registrar

## MEDICAL CERTIFICATION

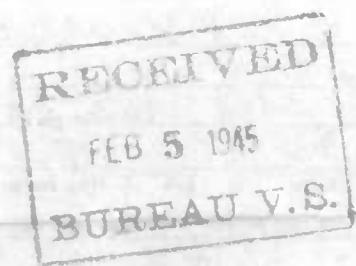
20. DATE OF DEATH: Jan 17 1945  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17 to Jan 13 1945 and that I last saw him alive on 1-13-45 1945

Immediate cause of death: arterio sclerosis  
 Due to: \_\_\_\_\_  
 Due to: \_\_\_\_\_  
 Other conditions: \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations: \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results: \_\_\_\_\_  
 PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide: \_\_\_\_\_ Date of: \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury: \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE: J V Shagg M.D. or other  
 Address: Mr. Braden Date signed: 1-18-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

00339

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll

County

Henryton

(If outside city or town limits, write RURAL and give nearest town)

18 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium

Colored Branch, Henryton, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

St. Paul &amp; 31st Street

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ZEB HOWELL

## 4. Sex

Male

## 5. Color or race

Colored

## 6.(a) Single, married, widowed, or divorced

Single

## B.(b) Name of husband or wife

5.(c) If alive, give age .....

years

## 7. Birth date of deceased (mo., day, yr.)

Dec., 25, 1889

## 8. AGE:

Years	Months	Days	If less than one day
55	0	9	hrs. min.

## 9. Birthplace

Monroe, N. C.

(Town, county, and state)

## 10. Usual occupation

Fireman

## 11. Industry or business

Charles Howell

Greenville, N. C.

## FATHER

## 12. Name

Adeline Morrow

## 13. Birthplace

Greenville, N. C.

## MOTHER

## 14. Maiden name

Reuben Hoffman, M. D.

## 15. Birthplace

Henryton, Maryland.

## 16. Informant

Henryton, Maryland.

## Address

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

1/3 1945

Albert R. Swembour

Deputy Local

Registrar

Date thereof (month) (day) (year)

Jan 7 1945

Month Day Year

1945

Signature

Albert R. Swembour

Address

Henryton, Md.

Date signed

1/3/45

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

January 3, 1945 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec., 16, 1945, to Jan., 3, 1945, and that I last saw him alive on January 3, 1945.

Immediate cause of death

Lobar Pneumonia

DURATION

11-15-44

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

Signature

Albert R. Swembour

Address

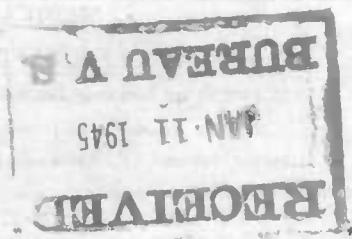
Henryton, Md.

M. D. or other

Date signed

1/3/45

DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
COMMUNICATIONS SECTION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 130

## CERTIFICATE OF DEATH

Reg. Dist. No. 0034076

## 1. PLACE OF DEATH:

County CarrollCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death all her lifeHospital, Institution, or street address where death occurred: Charles St.

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Ellen Hugler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

f.Col.widowed6. (b) Name of husband or wife Elmer Cross7. Birth date of deceased (mo., day, yr.) June 1869

8. (c) If alive, give age

years

8. AGE: 

Years	Months	Days	If less than one day
75	7	?	hrs. min.

9. Birthplace Westminster Carroll Md.  
(Town, county, and state)10. Usual occupation house work (servant)

## 11. Industry or business

12. Name Robert Hugler13. Birthplace Carroll Co. Md.14. Maiden name Jane Pye15. Birthplace Carroll Co. Md.16. Informant Miss Maggie HuglerAddress Charles St. Westminster Md.17. Burial, cremation, or removal. Which? Burial Date thereof 1/4/45  
(month) (day) (year)Cemetery or crematory Western Chapel Cen.Location Rural nr. Westminster Md.18. Funeral director J. S. Myers Jr.Address Charles St. Westminster Md.19. (Date rec'd by registrar) 1/3 19. (Date of death) 1/3/45 - of Pla (Cause of death)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll Co.City or town Charles St. Westminster  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war X

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 - 45 19. 11 at 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 19. to 1 - 1 - 45 1945

and that I last saw her alive on 12 - 31 - 44 1944

Immediate cause of death

Myocarditis (ctr)  
Hypertosis (ctr)

DURATION

years -

Due to

Due to

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings or operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date ofWhere did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. C. Jernette M.D.

M. D. or other

Address Washington Md. Date signed 1-3-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

00341

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County CARROLLCity or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 DAYS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

ELIZABETH S. JARMAN

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

FEMALEWHITEWIDOW

## 6. (b) Name of husband or wife

GEORGE JARMAN

## 7. Birth date of

deceased (mo., day, yr.)

MARCH 27, 1885

## 6. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

5998

hrs.

min.

## 9. Birthplace

MARYLAND

(Town, county, and state)

## 10. Usual occupation

NONE

## 11. Industry or business

## 12. Name

GEORGE SHAW

## 13. Birthplace

ENGLAND

## 14. Maiden name

MYRA FOREST

## 15. Birthplace

ENGLAND

## 16. Informant

MRS C. H. KABLE

## Address

WESTMINSTER, MD.

## 17. Burial (Burial, cremation, or removal. Which?)

Date thereof 1/8/45  
(month) (day) (year)Cemetery or crematory LOCUST PARK CEMETERY

Location

BALTIMORE, MD.

## 18. Funeral director

J. FRANCIS REESE

Address

WESTMINSTER, MD.

## 19. (Date rec'd by registrar)

19

4/1/45

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

City or town BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3213 West End Avenue

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

JANUARY 1 1945 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 7 1945 to Jan 4 1945, and that I last saw her alive on Jan 4 1945.

Immediate cause of death

Coronary  
declerosis

DURATION

2 hrs.Due to myocardial degeneration  
& arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

Address W. Glenn Speicher  
60 Easton Street Baltimore, Md. Date signed Feb 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

00342

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Spangler State Hospital

How long in hospital or institution?

15 yrs 4 mo

## 3. (a) FULL NAME

4. Sex

m w single

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal. Which?

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

C. Harry Allen  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Oct 26 1928 to Jan 27 1945 and that I last saw him alive on Jan 27 1945

Immediate cause of death

Broncho Pneumonia 3 da

Due to

Chronic Appendicitis 8

Other conditions

Epilepsy 49 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

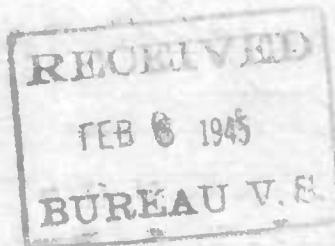
23. SIGNATURE

M. D. or other

Address Date signed

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

0034381

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

County

City or town *Union Bridge, Md*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Life time*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*William Henry Jones*

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

H

Married

B. (b) Name of husband or wife

*Bessie L. Jones*

1880 - 5

#

6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

1880 - 5 - 11

8. AGE:

Years 64

Months 8

Days 13

It less than one day

hrs.

min.

9. Birthplace

*Carroll Co*

(Town, county, and state)

10. Usual occupation

*Tabor*

11. Industry or business

FATHER

12. Name *Adam Jones*

MOTHER

13. Birthplace *Carroll Co*

FATHER

14. Maiden name *Anna Stonewifer*

MOTHER

15. Birthplace *Carroll Co*

16. Informant

*Mrs. Bessie Jones*

Address

*Union Bridge, Md*

17. Burial

Date thereof 1-21-45

(month) (day) (year)

(Burial, cremation, or removal, which?)

*Luthern Cemetery*

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19.

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*January 18 1945 at 2:00 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

Immediate cause of death

*benigny ulceration*

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

*James T. Moran, Deputy Medical Examiner*

M. D. or other

Address

*Needham Md*Date signed *1/15/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

*Misland by  
Registrar  
Marguerite P. Englar*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

00344

## CERTIFICATE OF DEATH

Reg. Dist. No. 71

## 1. PLACE OF DEATH:

County *Baltimore*City or town *Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 yrs.*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Rosada Kayler

4. Sex *F*5. Color or race *W*6. (a) Single, married, widowed, or divorced *W*6. (b) Name of husband or wife *Howard Kayler*7. Birth date of deceased (mo., day, yr.) *Jan. 22, 1921*6. (c) If alive, give age *years*8. AGE: Years *24* Months *0* Days *14* less than one day *hrs. 0* min. *0*9. Birthplace *Baltimore, Md.* (Town, county, and state)10. Usual occupation *None*

## 11. Industry or business

12. Name *James Elias Wilson*13. Birthplace *Baltimore, Md.*14. Maiden name *Amelia Sprinkle*15. Birthplace *Baltimore, Md.*16. Informant *Mrs. Paul Will*Address *Baltimore, Md.*17. Burial Date thereof *Jan. 8-1945* (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Wilton Cem.*Location *Baltimore, Md.*18. Funeral director *X. B. Bankert, Son*Address *Baltimore, Md.*19. Date rec'd by registrar *Jan. 8 1945* Marguerite P. Englar

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Baltimore* (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

*None*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan. 6 1945*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Apr. 2 1944, to Jan 6 1945* and that I last saw her alive on *Jan 6 1945*

Immediate cause of death

*Cerebral hemorrhage*

Due to

*arteria splanchnica*

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

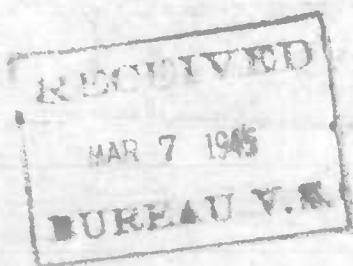
Means of injury

Injured at work?

23. SIGNATURE *J. J. Heger*

M. D. or other

Address *Elmwood Park*Date signed *Jan. 6-45*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

## CERTIFICATE OF DEATH

00345 76  
(74)

Reg. Dist. No.

## 1. PLACE OF DEATH:

County CarrollCity or town Springfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

Louise Kline

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. W. Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 23, 1884

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

60

8

6

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Nurse

11. Industry or business

FATHER

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

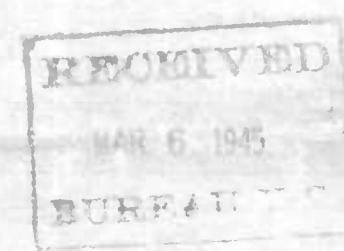
Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Date thereof (month) (day) (year)



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

00346

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County CarrollCity or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

ANNIE BETTIE KNAUDER

4. Sex <u>FEMALE</u>	5. Color or race <u>WHITE</u>	6. (a) Single, married, widowed, or divorced <u>WIDOW</u>
----------------------	-------------------------------	---

6. (b) Name of husband or wife SARAH7. Birth date of deceased (mo., day, yr.) DECEMBER 26, 18528. AGE: Years 92 Months 0 Days 18 It less than one day hrs. min.9. Birthplace CARROLL CO. MD.  
(Town, county, and state)10. Usual occupation NONE

11. Industry or business

12. Name JOHN H. SHENBRIDGE13. Birthplace VIRGINIA14. Maiden name BARBARA WHITTINGTON15. Birthplace VIRGINIA16. Informant JESSIE KNAUDERAddress WESTMINSTER, MD.17. Burial date 1/16/45  
(Burial, cremation, or removal. Which?) Date thereof 1/16/45  
(month) (day) (year)Cemetery or crematory WESTMINSTERLocation WESTMINSTER, MD.18. Funeral director J. FRANCIS REFSFAddress WESTMINSTER, MD.19. 1/15 19 1/20  
(Date rec'd by registrar) Geofford  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CarrollCity or town WESTMINSTER  
(If outside city or town limits, write RURAL and give nearest town)Street No. 32 W. GEORGE ST  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 13 1945 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1945 to January 13 1945 and that I last saw her alive on January 10 1945.Immediate cause of death Obstetrical hemorrhage DURATION 3 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

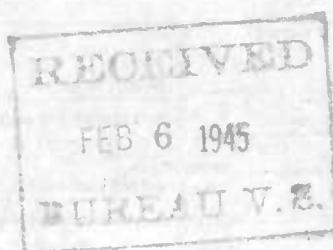
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

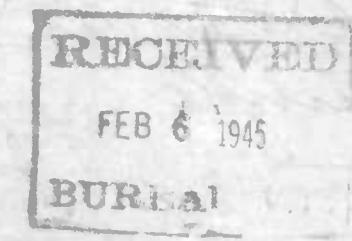
Means of injury

Injured at work?

23. SIGNATURE Frances Bon (Fr. B.)M. D. or other Westminster, Maryland Date signed 1/13/45  
Address







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00348

30-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

## 1. PLACE OF DEATH:

County Carroll

City or town rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yr., 8 mo., 27 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 3 yr., 8 mo., 27 days

## 3. (a) FULL NAME

Louis John Loritz

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Mary Estella Oswinkle

7. Birth date of

deceased (mo., day, yr.) August 15, 1883

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

61

4

28

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Millwright

11. Industry or business

Bethlehem Steel Company

MOTHER

FATHER

Henry Loritz

Baltimore, Maryland

MOTHER

FATHER

Katherine Eckles

Baltimore, Maryland

16. Informant

Springfield State Hosp. records

Address

Sykesville, Maryland

17. Cemetery or crematory

Location

Oak Lawn Cemetery

Location

Baltimore, Md.

18. Funeral director

Address

A. Sanders &amp; Son

North Ave &amp; Broadway

19. Date rec'd by registrar

Jan. 14 1945

(Date rec'd by registrar)

C. Harry May

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1518 N. Collington Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1945 4:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to January 13 1945

and that I last saw him alive on January 13 1945

Immediate cause of death Aortic aneurysm, prior to

Duration 11-28-44

Due to Syphilis (general paresis) prior to 1930

Due to Diabetes mellitus, prior to 1941

Other conditions Psychoneurosis, reactive depression 9 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

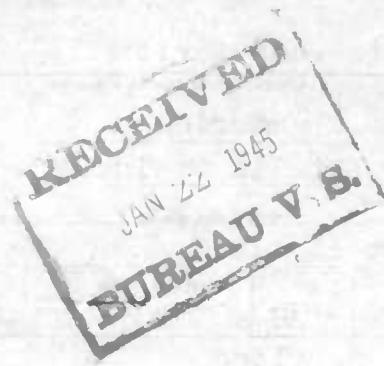
Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE Robert Bertrand May, M.D.

Springfield State Hospital M.D. of other

Address Sykesville, Maryland Date signed 1-13-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00349

## CERTIFICATE OF DEATH

Reg. Dist. No. 78

## 1. PLACE OF DEATH:

County BarrollCity or town Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Lloyd W. Mason

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MWwidower

6. (b) Name of husband or wife

Mary A. Mason

7. Birth date of deceased (mo., day, yr.)

Aug 21, 1864

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80418

hrs. min.

9. Birthplace

(Town, county, and state)

Md

10. Usual occupation

Stationary Fireman

11. Industry or business

John Mason

12. Name

John Mason

13. Birthplace

Md

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

J. A. Mason

Address

Westminster #7

17. Burial

BurialDate thereof Jan 10, 1945

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Meadow Branch

Location

Md

18. Funeral director

J. A. Mason & Son

Address

Janeytown, Md

19. Date rec'd by registrar

Jan 91945Ethel M. Meadley

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

213-18-1709

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 8 1945 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1944 to Jan 1945and that I last saw him alive on Jan 6 1945

Immediate cause of death

Arteriosclerotic heart disease  
& hypertension

DURATION

1 yr.

Due to

Cerebral softening

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Walter A. Katz M.D. M. D. or otherAddress Westminster Date signed 1/9/45

T

RECEIVED

FEB 6 1945

BUREAU

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

00350

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 11 mos

Hospital, institution, or street address where death occurred

Springfield State Hosp.

How long in hospital or institution? 1 yr 11 mos

## 3. (a) FULL NAME

Anna R McCardell

## 3. (b) Social Security Number

4. Sex

5. Color or race W

6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife

husband

7. Birth date of deceased (mo., day, yr.)

Oct 25 - 1861

B.(c) If alive, give age years

8. AGE:

Years 83

Months 3

Days 2

If less than one day

9. Birthplace

(Town, county, and state)

Maryland

10. Usual occupation

housewife

11. Industry or business

Timothy Ryan

12. Name

Ireland

13. Birthplace

Ann McGinnery

14. Maiden name

Alice Lynch

15. Birthplace

Ireland

16. Informant

Hamilton Blv - Hagerstown

17. Burial

Date thereof Jan 26 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

Andrew N Coffman

Address

Hagerstown, Md.

19. Date rec'd by registrar

Jan 28 1945

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 27 1945 at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Get 27 1943 to Jan 27 1945

and that I last saw h. alive on Jan 27 1945

Immediate cause of death

Bronchitis Pneumonia 8da

Due to

Hypertension 2 mo

Due to

Atherosclerosis 15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

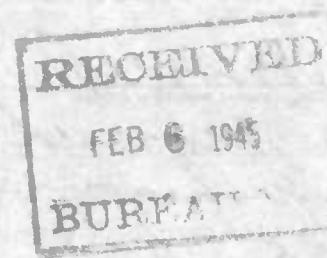
Address Sykesville Md Date signed Jan 27 1945

VS A15 T

LETTERS TO THE EDITOR OF THE STATE OF MARYLAND

LETTERS TO THE EDITOR OF THE STATE OF MARYLAND

LETTERS TO THE EDITOR OF THE STATE OF MARYLAND



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 840

00351

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH: Carroll

County

rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

26 yr., 8 mo., 21 days

How long in above place of death?

Springfield State Hospital

26 yr., 8 mo., 21 days

How long in hospital or institution?

## 3. (a) FULL NAME

John McDonald

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

Married

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 8, 1865

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

79

3

13

hrs.

min.

9. Birthplace: Baltimore City, Maryland

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

12. Name: Lawrence McDonald

13. Birthplace: Baltimore City, Maryland

14. Maiden name: Mary O'Brien

15. Birthplace: Baltimore City, Maryland

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial: Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Jan 24 1945

Cemetery or crematory: New Cathedral cem.

Location: Baltimore city

18. Funeral director: John W. Webes

Address: 404 S. Chester street

19. (Date rec'd by registrar) 1/23 1945 A.W. Hedrick  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State: County

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number  
none

## MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 1945 at 3:25a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Jan. 21 1945 and that I last saw him alive on January 20 1945.

Immediate cause of death

Senility

DURATION  
6 years

Due to

Due to

Other conditions: Alcoholic hallucinosis

28 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May  
Springfield State Hospital M.D. or other  
Address: Sykesville, Maryland Date signed 1-21-45

M

8

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-6

00352

## CERTIFICATE OF DEATH

74

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 10 mos., 29 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium

(Colored Branch), Henryton, Md.

How long in Hospital or Institution? same as above

## 3. (a) FULL NAME

SAM McELVEN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)	6.(c) If alive, give age..... years
Dec. 7, 1903	

8. AGE: Years	Months	Days	It less than one day
41	1	0	hrs. min.

9. Birthplace..... Williamsburg, S. C.  
(Town, county, and state)

10. Usual occupation..... laborer

11. Industry or business

12. Name	unknown
FATHER	"

13. Birthplace	"
MOTHER	"

14. Maiden name	unknown
MOTHER	"

16. Informant Reuben Hoffman, M.D.

Address Henryton, Md.

17. (Burial, cremation, or removal, which?)	Date thereof Jan. 9, 1945
	(month) (day) (year)

Cemetery or crematory	Hospital and School
Location	Baltimore, Md.

18. Funeral director F. H. Sander

Address 578 W. Biddle St

19. Jan. 7, 1945 (Date rec'd by registrar)

Alfred R. Sander  
deputy local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 703 Druid Hill Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

213-09-0720

## MEDICAL CERTIFICATION

2D. DATE OF DEATH January 7 1945 at 12:30<sup>a</sup>M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 8 1940 to January 7 1945

and that I last saw him alive on January 7 1945

Immediate cause of death

Pulmonary tuberculosis

DURATION

Oct.

1939

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md. Date signed 1-7-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00353

30-0

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:  
Carroll  
County

City or town... Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Springfield State Hospital

How long in hospital or institution? Seven days

## 3. (a) FULL NAME

Thomas Minor

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Mary Holbeard Minor

7. Birth date of deceased (mo., day, yr.) MAR 21 1885

8. AGE: Years	Months	Days	If less than one day
55	9	20	hrs. min.

9. Birthplace... York -

(Town, county, and state)

10. Usual occupation... Laborer

## 11. Industry or business

MOTHER FATHER	12. Name	John Minor
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MOTHER FATHER	13. Birthplace	Virginia
---------------	----------------	----------

MOTHER FATHER	14. Maiden name	Unknown
---------------	-----------------	---------

MOTHER FATHER	15. Birthplace	Virginia
---------------	----------------	----------

16. Informant	Gloyd Kearn
---------------	-------------

Address	Bustustown Md.
---------	----------------

17. (Burial, cremation, or removal. Which?)	Date thereof	Jan 13 45
---	--------------	-----------

Cemetery or crematory	Bustustown Methodist	
-----------------------	----------------------	--

Location	Bustustown	
----------	------------	--

18. Funeral director	J F Elmer Sons	
----------------------	----------------	--

Address	Bustustown Md.	
---------	----------------	--

19. (Date rec'd by registrar)	1/1/45	C Harry Elmer
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## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore

City or town... Pikesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1945 at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 4 1945 to Jan 10 1945  
and that I last saw h. m. alive on Jan 10 1945

## Immediate cause of death

Lobar Pneumonia (Bilateral)  
Terminal

Due to... Chronic myocarditis

Due to... Generalized arteriosclerosis

Other conditions... Syphilis  
Psychotic cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results... none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

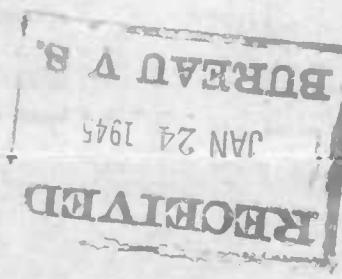
Injured at home, farm, industry, public place (where?)

Means of injury... Injured at work?

23. SIGNATURE... Edward F. Kerman

M. D. or other

Address... Sykesville, Md. Date signed 1-11-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

00354

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County CARROLLCity or town WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

CATHERINE H. MITCHELL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALEWHITEWIDOW6. (b) Name of husband or wife GEORGE H. MITCHELL

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ABOUT 18658. AGE: Years ABOUT 80 Months      Days      If less than one day      hrs.      min.9. Birthplace MARYLAND  
(Town, county, and state)10. Usual occupation NONE

11. Industry or business

12. Name NOT KNOWN13. Birthplace "14. Maiden name "15. Birthplace "16. Informant GEORGE R. MITCHELLAddress WESTMINSTER, MD.17. Burial BURIAL Date thereof 1/24/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory LOUISON PARK CEMETERYLocation BALTIMORE, MD.18. Funeral director W. FRANCIS REESEAddress WESTMINSTER, MD.19. 1/23/45 Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLLCity or town WESTMINSTER  
(If outside city or town limits, write RURAL and give nearest town)Street No. 230 E MAIN ST.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 22, 1945, at 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1941, Jan 22, 1945 and that I last saw her alive on Jan 22, 1945.Immediate cause of death myocardial degenerationDue to arteriosclerosis adult male 3 yrsDue to Other conditions 

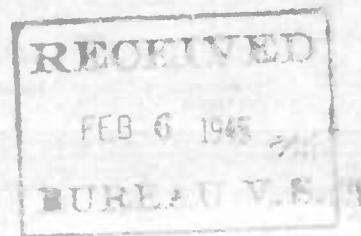
(Include pregnancy within 8 months of death)

Major findings of operations  Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE W. Reese Wilson M. D. or other MD Date signed 1/23/45Address Westminster



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 733

## CERTIFICATE OF DEATH

00355

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County

City or town

Carroll  
Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 yr 8 mo 18 da

Hospital, institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

1 yr 8 mo 18 da

## 3. (a) FULL NAME

Carrie Estella Hosts

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

unknown

7. Birth date of deceased (mo., day, yr.)

6 (c) alive, give age years

1886

8. AGE: Years

78

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Maryland

10. Usual occupation

Florence

11. Industry or business

Simon Coffman

FATHER

12. Name

Simon Coffman

MOTHER

13. Birthplace

Maryland

14. Maiden name

Mary Boyd

15. Birthplace

Maryland

16. Informant

Easly Coffman

Address

27 Glenelde Ave Hagerstown

Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof 1/3/45

Cemetery or crematory

Manor Cemetery

Location

Near Hagerstown Md

18. Funeral director

H K Coffman

Address

Hagerstown Md

19. Date rec'd by registrar

Jan 1 1945

C. Henry Lee

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Washington

City or town

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 1st 1945 at 9:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 16 1948 to Jan 1st 1945

and that I last saw her alive on Jan 1st 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 da

Due to

Arterialclerosis

days

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

H J Hartman M.D.

M. D. or other

Address: Sykesville Md Date signed: Jan 1 1945

RECEIVED

FEB 8 1945

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3001

00356

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County CARROLLCity or town NEAR WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11/11

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

VIENA O. MYERS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED

6. (b) Name of husband or wife FRANKLIN H. MYERS

7. Birth date of deceased (mo., day, yr.)

APRIL 11, 1859

8. (c) If alive, give age 82 years

8. AGE:

Years

Months

Days

If less than one day

85

8

24

hrs.

min.

9. Birthplace CARROLL COUNTY, MD.  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name CYRUS SCHWEIGART13. Birthplace MD.14. Maiden name NAT KENNAN15. Birthplace 11 1116. Informant MRS. H. G. SHAFFERAddress WESTMINSTER, MD.17. BURIAL  
(Burial, cremation, or removal. Which?)Date thereof 1/8/45  
(month) (day) (year)Cemetery or crematory KRIDER'S CEMETERYLocation WESTMINSTER, MD.18. Funeral director J. FRANCIS REESEAddress WESTMINSTER, MD.19. 1/6  
(Date rec'd by registrar) 19 81

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLLCity or town NEAR WESTMINSTER  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

NONE

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

JANUARY 4 1945 at 11:00 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

left 1st 1944 to Jan 1st 1945and that I last saw her alive on Jan 1st 1945

Immediate cause of death

Locomotive Ataxia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

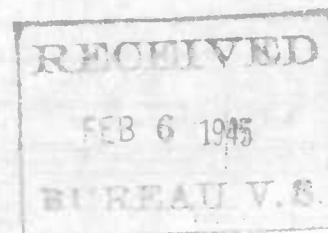
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Stewart  
Westminster  
M. D. or other  
Date signed Jan 7, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

00357

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... rural near Sykesville  
(If outside city or town limits, write RURAL and give nearest town)  
 Now long in above place of death? 5 months, 12 days  
 Hospital, Institution, or street address where death occurred: Springfield State Hospital  
 Now long in hospital or institution? 5 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....  
 City or town..... Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
(If rural, give LOCATION)

3. (a) FULL NAME  
 John Oppel

2.(a) If veteran, name war.....

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced  
 male white married

6.(b) Name of husband or wife Edna

7. Birth date of deceased (mo., day, yr.) November 13, 1883  
 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
 61 2 15 . . . . . hrs. . . . . min.

9. Birthplace..... Baltimore City, Maryland  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... Box factories

FATHER 12. Name..... John Oppel

13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Mary Rep

15. Birthplace..... Maryland

16. Informant..... Springfield State Hosp. records

Address..... Sykesville, Maryland

17. Burial..... Date thereof..... Jan. 31, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Olivet Cem.

Location..... Sykesville, Maryland

18. Funeral director..... John F. Deamer Inc.

Address..... 818 & Montgomery Sts.

19. Date rec'd by registrar..... Jan. 28, 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 28 1945 at 7:20a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1944 to Jan. 28 1945 and that I last saw him alive on January 27 1945

Immediate cause of death..... Cerebral hemorrhage 4½ hrs. DURATION

Due to..... Arteriosclerosis, prior to 1940

Due to.....

Other conditions..... Psychosis with cerebral arteriosclerosis, prior to 6-16-44  
(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

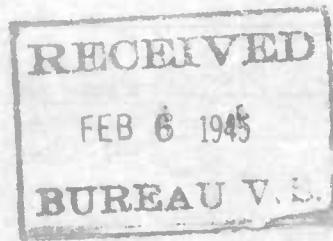
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.  
Springfield State Hospital M.D. or other  
 Address..... Sykesville, Maryland Date signed 1-28-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on  
FILM NO. G 92 MAR 10 1945

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

00358

## CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 mo 6 da

Hospital, institution, or street address where death occurred.....

Springfield State Hospital

How long in hospital or institution?.....

3 mo 6 da

## 3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

Unknown

7. Birth date of

deceased (mo., day, yr.)

Dec 17-1861

6. (c) If alive, give age..... years

8. AGE:

Years  
83

Months

Days

If less than one day

. hrs. . min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

John Patterson

13. Birthplace.....

Scotland

14. Maiden name.....

Unknown

15. Birthplace.....

Scotland

16. Informant.....

Mrs. Jessie Shely

Address.....

4901 E Oliver St. Baltimore

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Baltimore Cemetery

Location.....

5 North Ave

18. Funeral director.....

Wendell E. Humphreys

Address.....

1521 N. Broadway

19. (Date rec'd by registrar)

19.

Registrar.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Baltimore

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH.....

Jan 3 d 1945, et 6-45 a

Sept 26 1945 to Jan 3 1945

and that I last saw him alive on Jan 3 d 1945

## Immediate cause of death.....

Coronary Thrombosis 4 hrs

Due to..... Chronic Hypertension 1 mo

Due to..... Arterialclerosis 12 yrs

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings of operations.....

Date of op. Jan 3 1945

Autopsy result..... Coronary Thrombosis, Chronic Hypertension

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

## 23. SIGNATURE.....

M. D. or other M. D. or other

Address..... Sykesville Date signed Jan 3 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00359

468

## CERTIFICATE OF DEATH

Reg. Dist. No. 82

## 1. PLACE OF DEATH: Carroll

County

Mt. Airy Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Corwin C. Penn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

MARRIED.

8. (b) Name of husband or wife

Mertie H. Penn

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age 65 years

Sept. 30, 1873

8. AGE:

Years 71

Months 3

Days 28

If less than one day

hrs. min.

9. Birthplace

Carroll Co. Maryland

(Town, county, and state)

10. Usual occupation

FARMER (Retired)

11. Industry or business

MOTHER FATHER

12. Name Milton H. Penn

13. Birthplace Maryland

14. Maiden name Mary H. Grimes

15. Birthplace Maryland

16. Informant Mr. Ferris Penn

Address

Mt. Airy. Md.

17. Burial Cemetery, or removal (where)

Date thereof 1-30-45

(month) (day) (year)

Cemetery or crematory Bethel Church of God

Location Winfield Carroll Co. Md.

18. Funeral director

Address

G. W. Wall

19. Date rec'd by registrar

19

(State)

19

Date signed

19

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Carroll

City or town Mt. Airy

Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 28, 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 4, 1943 to Jan. 28, 1945

and that I last saw him alive on Jan. 28, 1945

Immediate cause of death

Carcinoma of stomach  
with General Detoxin's

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

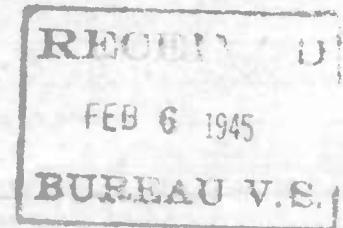
23. SIGNATURE

O. M. Hale, Jr.

M. D. or other

Address

Mt. Airy, Md. Date signed 1-28-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

00360

## CERTIFICATE OF DEATH

Reg. Dist. No. 71

## 1. PLACE OF DEATH:

County.....

City or town.....

*Carroll*  
*New Windsor* (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of ~~husband~~ wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years	Months	Days	It less than one day
68	11	14	hrs. min.

9. Birthplace

Frederick County, Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

W.M. R.R. Shops

12. Name

Melvin L. Perry

13. Birthplace

Maryland

14. Maiden name

Jennie Dyer

15. Birthplace

Maryland

16. Informant

Romeo P. Perry

Address

New Windsor, Md.

17. Burial

(Burial, cremation, or removal) (Which) Date thereof. Jan. 20 - 1945

(month) (day) (year)

Cemetery or crematory

Creeks Cemetery

Location

Chowtown Road

18. Funeral director

H. J. Haskins &amp; Sons

Address

Union Bridge, New Windsor, Md.

19. Date rec'd by registrar

January 19, 1945

(Date rec'd by registrar)

Margaret R. English

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

705-10-6022

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1945 at 6:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 16 1945 to Jan. 17 1945

and that I last saw him alive on Jan. 17 1945

Immediate cause of death.....

*Arthur Peters*  
*Special*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

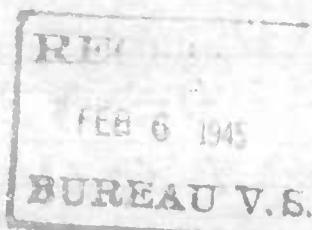
Means of injury.....

Injured at work?

23. SIGNATURE.....

J. N. Hogg M.D. or other

Address..... Union Bridge, Date signed 1-17-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

00361

## CERTIFICATE OF DEATH

Reg. Dist. No. 78

## I. PLACE OF DEATH:

County

Carroll - Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 3 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs. Verdie U. Pickett

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Gene Pickett

7. Birth date of deceased (mo., day, yr.)

Dec. 11, 1870

6. (c) If alive, give age years

8. AGE:

Years 74

Months 1

Days 8

If less than one day

hrs. .... min.

9. Birthplace

Carroll Co. Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

George W. Hearn

12. Name

MARYLAND

13. Birthplace

14. Maiden name

Catherine ?

15. Birthplace

MARYLAND

16. Informant

Mrs. William Hooper

Address

Mt. Airy, Md.

17. Burial

Date thereof 1-22-45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Taylorsville

Location Taylorsville Carroll Co. Md.

18. Funeral director

C. M. Waitz

Address Winfield, Md.

19. Jan. 21 1945

(Date rec'd by registrar)

E. M. Farmer

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 112 Mt. Airy

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 28 1945 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that it attended deceased from

1943 to Jan 29 1945

and that I last saw her alive on January 19 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 hr.

22. DISEASE

Hypertension Atherosclerosis

L-V disease

Years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

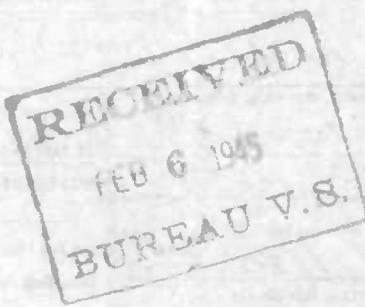
Injured at work

23. SIGNATURE

James T. Hearn

M. D. or other

Address New Windsor Md. Date signed 1/19/45





Rec'd. U. S.  
1/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00363

## CERTIFICATE OF DEATH

74

Reg. Dist. No. ....

1. PLACE OF DEATH:  
Carroll  
County .....  
City or town ..... Henryton  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? ..... 2 months, 21 days  
Hospital, Institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State ..... Maryland ..... County .....  
City or town ..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ..... 629 East 28th. St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

PATRICIA ALFREDA ROSS

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Divorced

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.) ..... Nov. 2, 1920

6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
24	2	28	hrs. ..... min.

9. Birthplace ..... Dinwiddie, Virginia  
(Town, county, and state)

10. Usual occupation ..... Waitress

11. Industry or business

FATHER 12. Name ..... Waverly Ross

13. Birthplace ..... Dinwiddie, Virginia

MOTHER 14. Maiden name ..... Clara Hardy

15. Birthplace ..... Dinwiddie, Va.

16. Informant ..... Reuben Hoffman, M.D.

Address ..... Henryton, Maryland

17. Removal ..... Date thereof ..... 11/31/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Petersburg Cemetery

Location ..... Petersburg, Virginia

18. Funeral director ..... Mrs. Edna Bailey

Address ..... 1421 Jefferson St

19. Jan. 30, 1945 Albert R. Swank, M.D.  
(Date rec'd by registrar) Deputy Local Registrar

## MEDICAL CERTIFICATION

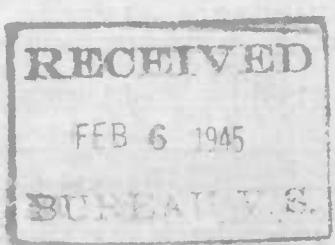
20. DATE OF DEATH ..... January 30, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9, 1944, to Jan. 30, 1945, and that I last saw her alive on Jan. 30, 1945.

Immediate cause of death ..... Pulmonary Tuberculosis  
DURATION ..... Nov. 1943Due to .....  
.....Due to .....  
.....Other conditions .....  
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results .....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ..... Date of .....  
.....Where did injury occur? ..... (City or town) ..... (County) ..... (State)  
.....Injured at home, farm, industry, public place (where?) .....  
.....Means of Injury ..... Injured at work? .....  
.....23. SIGNATURE ..... Reuben Hoffman, M.D.  
M. D. or other .....  
Address ..... Henryton, Md. Date signed ..... 1-30-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20201

00364

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County BaltimoreCity or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

75

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Peter Milton Ruthrauff4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Fannie Blair7. Birth date of deceased (mo., day, yr.) July 26 1867 6. (c) If alive, give age ..... years8. AGE: Years 77 Months 5 Days 6 If less than one day hrs. ..... min.9. Birthplace Westminster, Md. (Town, county, and state)10. Usual occupation Carpenter, Draftsman

11. Industry or business

12. Name Peter South Ruthrauff13. Birthplace Md.14. Maiden name Mary Anna Hauser15. Birthplace Md.16. Informant Mrs. John EverhartAddress 17 Hersh Ave, Westminster, Md.17. Burial, cremation, or removal (Which?) Burial Date thereof Jan 24, 1943 (month) (day) (year)Cemetery or crematory Kirkbride CemeteryLocation Westminster, Md.18. Funeral director H. Bankard, Jr.Address Westminster, Md.19. 1/3 1945 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Westminster (If outside city or town limits, write RURAL and give nearest town)Street No. 17 Hersh Ave. (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24, 1943 1943, at 1 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10 1943, to Jan 24 1943and that I last saw him alive on Jan 24 1943Immediate cause of death Cerebral Hemorrhage DURATIONDue to AgeDue to Due to Other conditions 

(Include pregnancy within 8 months of death)

Major findings of operations  Date of op. Autopsy results  PHYSICIAN: Please underline the cause to which death should be charged statistically.

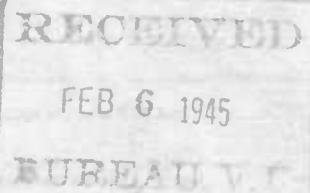
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury  Injured at work? 23. SIGNATURE John H. Bankard, Jr. M. D. or other MDAddress 1063 1/2 1945 Date signed 1/23/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of cause of death is shown on

FILM No. G 94 APR 7 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00365

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

### 1. PLACE OF DEATH:

County.

Carroll

City or town.

Gamber Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Gamber Md.

How long in hospital or Institution?

2 wks.

### 3. (a) FULL NAME

Mary A. Savage

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white married

Frank Savage

B. (b) Name of husband or wife

B. (c) If alive, give age 55 years

7. Birth date of

deceased (mo., day, yr.)

Dec 8 1900

8. AGE:

Years

Months

Days

If less than one day

44

1

3

hrs. min.

9. Birthplace

Carroll Co Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

John J. Dahn

13. Birthplace

Maryland

14. Maiden name

Elyse E. Honley

15. Birthplace

Maryland

16. Informant

Off. Frank Savage

Finksburg Md

Address

Burial

Date thereof 1-13-45

(month) (day) (year)

Cemetery or crematory

Providence

Location

Gamber Cemetery Co Md

18. Funeral director

C. M. Hall & Son

Address

Carroll

19. (Date rec'd by registrar)

1-17-45

Off. Frank Savage

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland

County

Carroll

City or town. Gamber Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH

January 11 1945 at 12 50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 15 1944 to Jan 11 1945, and that I last saw her alive on Jan 10 1945

Immediate cause of death

Intestinal Obstruction 1 wks DURATION

Due to

Gangrenous Peritonitis?

Probably primary carcinoma of the liver

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Gangrenous Peritonitis

Date of op. Nov 30, 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Joseph E. Bush M.D.

M. D. or other

Address

Hampstead Md Date signed 1-11-45

RECEIVED

FEB 6 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 230

## CERTIFICATE OF DEATH

Reg. Dist. No. 0036570

## 1. PLACE OF DEATH:

County CarrollCity or town Haneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Emma Jane Shildt

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Married

## 6.(b) Name of husband or wife

J. Theodore Shildt

## 7. Birth date of deceased (mo., day, yr.)

May 6, 1868

6.(c) If alive, give age years

## 8. AGE:

Years	Months	Days	If less than one day
76	8	0	hrs. min.

## 9. Birthplace

Maryland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

12. Name Tobias Stahl13. Birthplace Maryland14. Maiden name Susan Bowers15. Birthplace Penns.16. Informant Charles ShildtAddress Haneytown, R.D. Md.17. Burial Burial Date thereof January 9, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Haneytown, Md.18. Funeral director O. O. Guss/MonAddress Haneytown, Md.19. Jan 8, 1945 - Ethel M. Mehling

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Haneytown (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

none

Prior to

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1945, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19. to 19. \_\_\_\_\_ 19.

and that I last saw her alive on 19. 1945 19.Immediate cause of death Cerebral Hemorrhage

DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

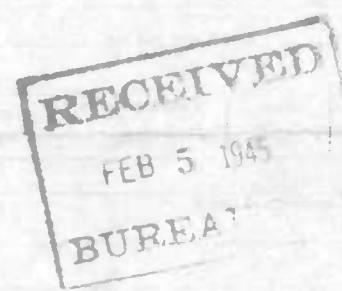
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James J. March Deputy Medical Examiner M. D. or otherAddress Jefferson 7th Date signed Jan 5, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 26

00367

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH: CARROLL  
 County .....  
 City or town ..... 1100 M. I. I.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? ..... 4 years  
 Hospital, Institution, or street address where death occurred: .....  
 How long in hospital or institution? .....  
 Hospital, Institution, or street address where death occurred: .....  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State ..... MARYLAND County ..... CARROLL  
 City or town ..... 1100 Mill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ..... R.D. 6 Westminster  
 (If rural, give LOCATION)

2.(a) If veteran, name war: .....

## 3. (a) FULL NAME

Mrs. MARY E. Shipley

## 3. (b) Social Security Number

4. Sex ..... Female 5. Color or race ..... White 6. (a) Single, married, widowed, or divorced ..... Widowed.  
 B. (b) Name of husband or wife ..... F. Carroll Shipley.

7. Birth date of deceased (mo., day, yr.) ..... Sept. 5, 1868  
 B. (c) If alive, give age ..... years

8. AGE: Years ..... 76 Months ..... 4 Days ..... 13 If less than one day .....  
 hrs. ..... min.

9. Birthplace ..... CARROLL Co. MARYLAND.  
 (Town, county, and state)

10. Usual occupation ..... House work.

11. Industry or business ..... ESOP'S STIMAX

MOTHER FATHER  
 12. Name ..... ESOP'S STIMAX  
 13. Birthplace ..... GERMANY

14. Maiden name ..... Emily ?  
 15. Birthplace ..... GERMANY.

16. Informant ..... Mrs. Delta P. Eist.  
 Address ..... Sykesville, Md.

17. Burial ..... Burial Date thereof ..... 1-21-45  
 (Burial, cremation, or removal. Which?) Cemetery or crematory ..... Bethesda  
 Location ..... NEAR Eist, Carroll Co. Md.

18. Funeral director ..... G. W. Wall  
 Address ..... Wenfield, Md.

19. (Date rec'd by registrar) ..... 1/20 45 19. (Date of death) ..... 1/20/45  
 Registrar ..... W. Steele

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... JAN. 18 19 45 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 19 44 to Jan. 18 19 45 and that I last saw her alive on July 10 19 44.

Immediate cause of death ..... Acute Coronary Thrombosis. DURATION 2 hrs

Due to ..... General Arterio-vascular disease DURATION 5 yrs.

Due to ..... Ob. Myocarditis DURATION 2 yrs.

Other conditions .....  
 (Include pregnancy within 8 months of death)

Major findings of operations ..... Date of op. ....

Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) ..... (County) ..... (State)

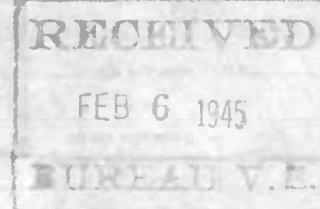
Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....

23. SIGNATURE ..... Shirley Rose M. D. or other ..... W. Steele M. D. Date signed ..... 1/19/45

Address .....  
 (Address) .....  
 Date signed ..... 1/19/45

STATE OF TEXAS

CERTIFICATE OF MAIL



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

00368

## CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH: Carroll  
 County Rural - Winfield  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, Institution, or street address where death occurred:  
 How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Mrs. Mary Jane Shipley

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Hamlet Almer Shipley

7. Birth date of deceased (mo., day, yr.) Aug 31, 1863 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: 81 Years 4 Months 21 Days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual occupation None

## 11. Industry or business

FATHER 12. Name George H. Barnes  
 13. Birthplace MARYLAND

MOTHER 14. Maiden name Ann BeCraft  
 15. Birthplace MARYLAND

16. Informant Miss Matilda Shipley

Address Sykesville, Md.  
 17. BURIAL (Burial, cremation, or removal, which) BURIAL Date thereof 1-24-45  
 (month) (day) (year)

Cemetery or crematory Ebenezer

Location Winfield, Carroll Co. Md.

18. Funeral director G. M. Wall

Address Winfield, Md.

19. (Date rec'd by registrar) Jan 23 1945 - Edna M. Heath - Deputy Local Registrar  
 M. D. or other Medicinal Date signed 1/23/45

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll  
 City or town Rural - Winfield (If outside city or town limits, write RURAL and give nearest town)  
 Street No. P.O. Sykesville (If rural, give LOCATION)

## 2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1945 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1st 1945 to Jan 22 1945 and that I last saw her alive on Jan 21 1945.

## Immediate cause of death

arteriosclerotic cardiovascular disease

## DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

## Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

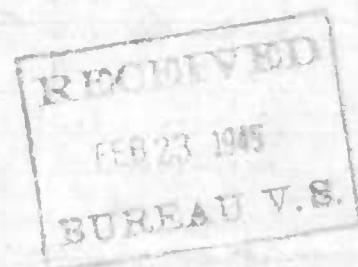
## Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE James T. Shand

M. D. or other

Address Medicinal Rd Date signed 1/23/45



270.116-2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

00369

82

Reg. Dist. No.

## CERTIFICATE OF DEATH

1. PLACE OF DEATH: Carroll

County

City or town Ridgeville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Gertrude Smith4. Sex Female Color or race White 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife Ernest Smith7. Birth date of deceased (mo., day, yr.) Dec. 9, 1875 6. (c) If alive, give age 74 years8. AGE: Years 69 Months 0 Days 24 It less than one day hrs. 0 min. 09. Birthplace Howard Co. Maryland (Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

MOTHER FATHER 12. Name William W. Pickett13. Birthplace Maryland14. Maiden name Amanda Bowman15. Birthplace Maryland16. Informant Mr. Ernest SmithAddress Mt. airy bed17. Burial Burial Date thereof 1-6-45 (Burial, cremation, or removal? Which?) (month) (day) (year)Cemetery or crematory Pine GroveLocation Mt. airy, Carroll Co. Md.18. Funeral director G. W. WallAddress Wenfield bed.19. 115 Date rec'd by registrar 19

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Ridgeville (If outside city or town limits, write RURAL and give nearest town)Street No. RD. Mt. airy. (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 3, 1945 at 8:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2, 1940, to December 3, 1945, and that I last saw h. er alive on 1945.

## Immediate cause of death

Cerebral Hemorrhage (3) DURATION 5<sup>th</sup> 3<sup>rd</sup> 2<sup>nd</sup>Due to Arterio SclerosisDue to HypertensionOther conditions 6th. Myocarditis

(Include pregnancy within 3 months of death)

Major findings or operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

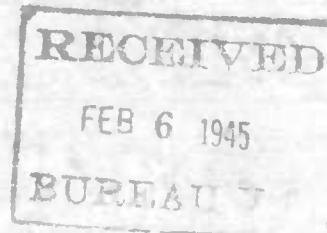
23. SIGNATURE J. Stanley Grubill

M. D. or other

Address Mt. airy, Md. Date signed 1/5/45

RECEIVED BY TELETYPE UNIT - STATE OF WISCONSIN

REASON TO SUSPENDED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137

00370

## CERTIFICATE OF DEATH

74  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Carroll

City or town Henryton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

MILDRED ALVERA STEEPLE

4. Sex female 5. Color or race col. 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Matthew Steeple

7. Birth date of deceased (mo., day, yr.) April 19, 1907 8. (c) If alive, give age 40 years

8. AGE: Years Months Days It less than one day  
37 8 16 . . . . . hrs. . . . . min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name John Hamilton

13. Birthplace Frederick, Md.

MOTHER 14. Maiden name Lavanina Dennis

15. Birthplace Baltimore, Md.

16. Informant Reuben Hoffman, Md.

Address Henryton, Md.

17. Burial Date thereof Jan 9/1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary Cemetery

Location A. A. G. S. Md.

18. Funeral director Rufus Williams

Address 1575 M-Ederry St.

19. Jan. 4, 1945 Albert R. Hoffman

(Date rec'd by registrar) Deputy Local Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Baltimore

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 727 Sterling St.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH January 4, 1945 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 23, 1944, to Jan. 4, 1945

and that I last saw her alive on January 4, 1945.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

May 1944

Due to

Due to

Other conditions

(Indicate pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Reuben Hoffman, M.D.

M. D. or other

Address Henryton, Md.

Date signed 1-4-45

Bad 145  
Am 78

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## MARGIN RESERVED FOR BINDING

M.  
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1. PLACE OF DEATH

County CarrollVillage or City Westminster

61

Registration Dist. No. 7600371  
76Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U.S. if of foreign birth? 0 yrs. 0 mos. 0 ds.2. FULL NAME Jess Lewis Stover(a) Residence No. 

(Usual place of abode)

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

St.

Ward

If U. S. Veteran, specify WAR St.  Ward. 

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED,

OR DIVORCED (write the word)

married

5a. If married, widowed, or divorced

HUSBAND of Ann Rebecca Bush  
(or) WIFE of 6. DATE OF BIRTH (month, day, and year) March 23 - 1866

7. AGE

Years 78Months 9Days 16If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc. Farmer: Ret.9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc. 10. Date deceased last worked at  
this occupation (month and  
year) 14-2411. Total time (years)  
spent in this  
occupation

12. BIRTHPLACE (city or town)

(State or country) Carroll Co. Md.

MOTHER FATHER

13. NAME Ezra Stover

14. BIRTHPLACE (city or town)

(State or country) Carroll Co. Md.15. MAIDEN NAME Clarissa Wampler

16. BIRTHPLACE (city or town)

(State or country) Carroll Co. Md.17. INFORMANT Clayton Stover(Address) W. Garfieldburg, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Sandymount cem. Date Jan 12, 194519. UNDERTAKER W. Bankard & Son(Address) Westminster, Md.20. FILED 1/11

, 19

45 Monday

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Jan 10  
(Month) 1945  
(Day) 1945  
(Year)

22. I HEREBY CERTIFY, That I attended deceased from

May, 1944, to Jan 10, 1945I last saw him alive on Jan 10, 1945; death is said  
to have occurred on the date stated above, at 12:57 P.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Congestive Heart FailureArteriosclerotic heart  
disease

Other Contributory Causes of Importance:

Diabetes mellitus

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Million A. Katz

M. D.

(Address) W. Es. Mortuary, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

Date of onset

Arteriosclerosis

1915

Chronic interstitial nephritis

1921

Cerebral hemorrhage

July 5, 1927

## Example II

The principal cause of death and related causes of importance were as follows:

Date of onset

Attack of epilepsy

1 week ago

Run over by street car

1 week ago

Peritonitis

FEB 6 1928

3 days ago

Other contributory causes of importance:

Gallstones

May 1, 1928

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1566

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs 7-21

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Milton Augustus Sullivan

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced married

## 8. (b) Name of husband or wife

Lorraine M. Little

66 years

## 7. Birth date of deceased (mo., day, yr.)

May 28 1878

## 8. AGE:

Years 65

Months 7

Days 21

If less than one day hrs. min.

## 9. Birthplace

Westminster Md.

(Town, county, and state)

## 10. Usual occupation

Real estate broker

## 11. Industry or business

George W. Sullivan

## 12. Name

George W. Sullivan

## 13. Birthplace

Md.

## 14. Maiden name

Lucinda Miller

## 15. Birthplace

Md.

## 16. Informant

Lorraine M. Sullivan

## Address

15 Milton Ave, Westminster, Md.

Date thereof Jan. 21-1945

(month) (day) (year)

## 17. Burial

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

Bridges Cemetery

## Location

Westminster Md.

## 18. Funeral director

H B Bankard &amp; Sons

## Address

Westminster Md.

## 19. (Date rec'd by registrar)

1/20/45

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Milton Ave. Westminster

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

January 19 1945 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6 1944 to January 19 1945

and that I last saw her alive on January 19 1945

## Immediate cause of death

Respiratory Failure  
due to pneumonia of bronchitis  
Due to of respiration

Due to hypothermia

## DURATION

3 hours

10 hours

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

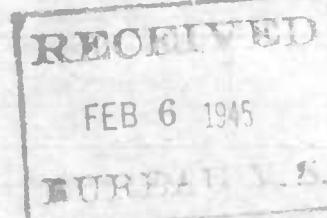
## Means of injury

Injured at work?

## 23. SIGNATURE

Dreher Bon M. D. or other

Address Rosemont Ave. Date signed 1/19/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-10

00373

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

Carroll County

City or town: Sykesville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years, 1 month

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 15 years, 1 month

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

Washington County

City or town: None

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elsie Irene True

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 14, 1914

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Washington County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

York

13. Birthplace

MOTHER

14. Maiden name

York

15. Birthplace

16. Informant

Rev. Wm. Houck

Address 935 Washington Boulevard,  
Baltimore, Maryland

17. Burial

Date thereof Jan 10 1945

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Springfield State Hospital

Location

Sykesville, Md.

18. Funeral director

C. G. Gray, Esq.

Address

Sykesville, Md.

19. Date rec'd by registrar

Jan 10 1945

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 6, 1945, at 1:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 4, 1944, to Jan 6, 1945, and that I last saw her alive on Jan 6, 1945.

Immediate cause of death

Pulmonary tuberculosis

DURATION

4 mos. +

Due to

Due to

Other conditions

Schizophrenia

(Include pregnancy within 3 months of death)

15 yrs.

Major findings or operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

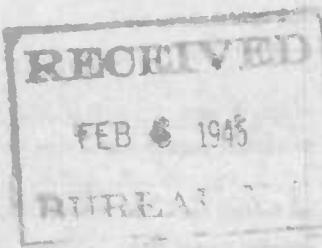
Injured at work?

23. SIGNATURE

Edward F. Kerman

M. D. or other

Address Sykesville, Md. Date signed 1-8-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00374

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
 County.....  
 City or town..... Henryton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months, 2 days  
 Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium  
 Colored Branch, Henryton, Md.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 122 S. Bond St.  
 (If rural, give LOCATION)

3. (a) FULL NAME  
 HODGES TURNER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	colored	married

B. (b) Name of husband or wife..... Lucille Turner

6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) December 15, 1896

8. AGE: Years	Months	Days	If less than one day
48	0	29	hrs. min.

9. Birthplace..... Suffolk, Virginia  
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

FATHER	12. Name..... Joe Turner
MOTHER	13. Birthplace..... Suffolk, Va.

MOTHER	14. Maiden name..... Unknown
	15. Birthplace..... Unknown

16. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial, cremation, or removal. Which? Bureau Date thereof Jan. 16th/45  
 (Burial, cremation, or removal. Which?)  
 Cemetery or crematory m & Calver Location Brookland mtd

18. Funeral director..... Elroy Wilson  
 Address..... 1000 Brantley St.

19. Jan. 13, 1945 Albert R. Hankins  
 (Date rec'd by registrar) Deputy Local Registrar

2. (a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13, 1945, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1944, to Jan. 13, 1945, and that I last saw h. im. alive on Jan. 13, 1945.

Immediate cause of death..... Pulmonary Tuberculosis DURATION Aug. 1943

Due to.....

Due to.....

Other conditions.....

(Includes pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D. M. D. or other

Address..... Henryton, Md. Date signed..... 1-13-45



M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

00375

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: CarrollCounty HypervilleCity or town (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? less than 24 hoursHospital, institution, or street address where death occurred: Springfield State HospitalHow long in hospital or institution? less than 24 hours

3. (a) FULL NAME

WILLIAM WALLACE WALKER

4. Sex

5. Color or race Male White 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 1, 1898 6. (c) If alive, give age ..... years8. AGE: 46 Years 6 Months 25 Days If less than one day hrs. min.9. Birthplace Springfield Kentucky (Town, county, and state)10. Usual occupation Glover11. Industry or business unknown12. Name Albert Manning Walker13. Birthplace Springfield, Ky.14. Maiden name Martha Taylor15. Birthplace unknown16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29 1945 (month) (day) (year)Cemetery or crematory SpringfieldLocation Springfield, Kentucky18. Funeral director Wade & EdelenAddress Springfield, Kentucky19. Date rec'd by registrar Jan. 26 1945 C. Harry Wren Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town (If outside city or town limits, write RURAL and give nearest town)Street No. unknown (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1945 at 9:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24 1945 to January 25 1945 and that I last saw him alive on January 25 1945

Immediate cause of death

Acute Alcoholic Intoxication DURATION 1 week

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

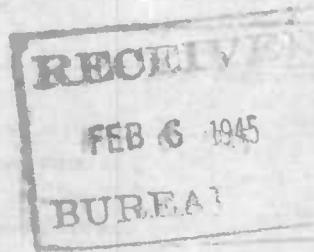
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arnold H. Eident, M.D. M. D. or otherAddress St. Marys, Carroll, Md. Date signed 1-26-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00376

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County

CARROLL

City or town

FALLS PETERSBURG

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1/2 FE

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

ELEANOR WARD

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOW

6. (b) Name of husband or wife

HAROLD E. WARD

7. Birth date of

deceased (mo., day, yr.)

JULY 17, 1885

years

8. AGE:

Years

Months

Days

It less than one day

59

6

13

hrs.

min.

9. Birthplace

CARROLL COUNTY, MD.

(Town, county, and state)

10. Usual occupation

ALONE

11. Industry or business

GEORGE CRESS

12. Name

GERMANY

13. Birthplace

MARYLAND

14. Maiden name

MARY DUTROW

15. Birthplace

MARYLAND

16. Informant

JAMES S. WARD

Address

BALTIMORE, MD.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

LEISTER'S CEMETERY

Location

NEAR WESTMINSTER, MD.

18. Funeral director

J. FRANCIS REESE

Address

WESTMINSTER, MD.

19. (Date rec'd by registrar)

19

45

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborns give residence of mother)

State

MARYLAND

County

CARROLL

City or town

FALLS PETERSBURG

(If outside city or town limits, write RURAL and give nearest town)

Street No.

76

(If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

JAN 30

19

45 2100P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10

to

19

and that I last saw h. alive on

19

Immediate cause of death

Fracture skull, rt. fracture eth. bone, fracture left fibula &amp; tibia

Due to

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

1/30/45

Where did injury occur

Fallsburg, Carroll

(City or town)

(State)

Injured at home, farm, industry, public place (where?)

Route 140

Means of injury

Hit by automobile

Injured at work?

No

23. SIGNATOR

J. Francis Reese, M.D., Medical Examiner

M. D. or other

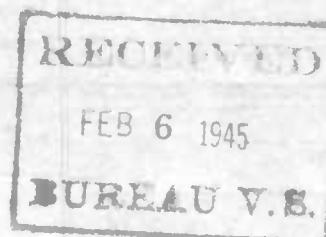
Address

New Windsor

76

Date signed

1/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00377

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:  
County..... Carroll

City or town..... Henryton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 month, 30 days

Hospital, Institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 929 N. Mount Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

ESTHER WATSON

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

female colored married

6.(b) Name of husband or wife..... Alexander Watson

6.(c) If alive, give age..... 24 years

7. Birth date of deceased (mo., day, yr.)..... November 25, 1923

8. AGE: Years..... Months..... Days..... If less than one day  
21 1 22 ..... hrs. ..... min.

9. Birthplace..... Virginia  
(Town, county, and state)

10. Usual occupation..... Domestic

11. Industry or business.....

12. Name..... Claybrooke Carter

13. Birthplace..... Virginia

14. Maiden name..... Minnie Nutt

15. Birthplace..... Virginia

18. Informant..... Reuben Hoffman, M.D.

Address..... Henryton, Maryland

17. Burial Date thereof..... Jan 20 1945  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Mt. Auburn Cem.

Location..... Baltimore Md.

18. Funeral director..... Metropolitan Funeral Home Inc.

Address..... 927 N. Mount St.

19. Jan. 16, 1945 Albert L. Sowash  
(Date rec'd by registrar) Deputy Locat. Registrar

3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 16, 1945, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17, 1944, to Jan. 16, 1945, and that I last saw her alive on January 16, 1945.

Immediate cause of death..... Pulmonary Tuberculosis

DURATION  
July 1940

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

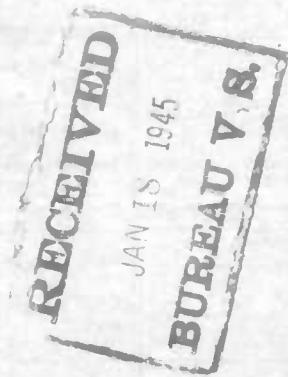
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Reuben Hoffman, M.D.

M. D. or other

Address..... Henryton, Md. Date signed 1-16-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00378

108

## CERTIFICATE OF DEATH

Reg. Dist. No. 3074

## 1. PLACE OF DEATH:

County

City or town

Carroll

Lyndale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 yr 9 mo 1/da

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

1 yr 9 mo 1/da

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

George Leyell

13. Birthplace

14. Maiden name

Clara Lee Berry

15. Birthplace

16. Informant

Mrs Ruth Fink

Address

3800 Republic Ave Baltimore

17. Burial, cremation, or removal. Which?

Burial Date thereof Jan 9, 1945

(month)

(day)

(year)

Cemetery or crematory

Bellevue

Location

Elkridge, Md

18. Funeral director

Cuddick &amp; Cole

Address

1700 Maryland St

19. (Date rec'd by registrar)

19

20. (Date signed)

1/24/45

Registrar

Address

Lyndale

Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 20, 1943, to Jan 5, 1945

and that I last saw her alive on Jan 5, 1945

Immediate cause of death

Dental sepsis

DURATION

Due to

Chronic Myocarditis

20 yrs

Due to

Arterio Sclerosis

20 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

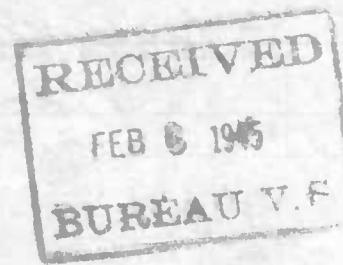
M. D. or other

Address

Signature

Date signed

5/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00379

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:  
County Carroll  
City or town Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 month, 7 days  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Md.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 677 George Street  
(If rural, give LOCATION)

3. (a) FULL NAME  
Sallie May Williamson

3. (b) Social Security Number  
219-05-7688

4. Sex **female** 5. Color or race **colored** 6. (a) Single, married, widowed, or divorced **married**

6. (b) Name of husband or wife **Dent Williamson**

7. Birth date of deceased (mo., day, yr.) **May 2, 1908** 8. (c) If alive, give age **years**

8. AGE: Years **36** Months **8** Days **1** If less than one day **hrs. min.**

9. Birthplace **Shelby, North Carolina** (Town, county, and state)

10. Usual occupation **Housewife**

11. Industry or business **at home**

12. Name **Albert Lutz**

13. Birthplace **North Carolina**

14. Maiden name **Mary Ross**

15. Birthplace **North Carolina**

16. Informant **Reuben Hoffman, M. D.**

Address **Henryton, Maryland.**

17. Removal **Removal** Date thereof **Jan. 5, 1945**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location **King Mountain, N.C.**

18. Funeral director **adolphus Goldstein**

Address **918 Druid Hill Ave**

19. **1/3** **45** **Albert R. Williamson**  
(Date rec'd by registrar) **Deputy Local** **Registrar**

## MEDICAL CERTIFICATION

20. DATE OF DEATH **January 3, 1945** at **6.00 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Nov. 27, 1944** to **Jan. 3, 1945** and that I last saw her alive on **January 3, 1945**.

Immediate cause of death **Pulmonary Tuberculosis** DURATION **Aug. 8th 1944**

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE **Reuben Hoffman, M.D.** M. D. or other

Address **Henryton, Md.** Date signed **1/3/45**

RECEIVED BY THE NATIONAL SECURITY COUNCIL

RECEIVED BY THE NATIONAL SECURITY COUNCIL



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00380

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:  
Carroll  
County

Henryton  
City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr, 2 mo., 10 days

Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Maryland.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

Maryland  
State

County

Baltimore  
City or town

(If outside city or town limits, write RURAL and give nearest town)

1634 E. Madison St.,  
Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3.(a) FULL NAME

DELORES ESTELLE WILSON

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

B.(b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)

6.(c) If alive, give age..... years

July 21, 1932

8. AGE:	Years	Months	Days	If less than one day
	12	6	1	hrs. min.

9. Birthplace.....  
(Town, county, and state)

Baltimore, Md.

Scholar

10. Usual occupation.....

11. Industry or business.....  
at school

Willie Wilson

12. Name.....  
MOTHER FATHER

Durham, N. Carolina

13. Birthplace.....  
Grace Hayes

14. Maiden name.....  
Hopewell, Va.

15. Birthplace.....  
Reuben Hoffman, M. D.

16. Informant.....  
Address

Henryton, Md.

17. Burial.....  
(Burial, cremation, or removal, etc.)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Location.....

18. Funeral director.....

Address

19. 1/22.....19.....45.....

(Date rec'd by registrar)

Deputy Local

Registrar

## 3.(b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

January 22, 1945, at 12.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov., 12, 1943, to Jan., 22, 1945,

and that I last saw her alive on January 22, 1945.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

Jan.  
1938

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

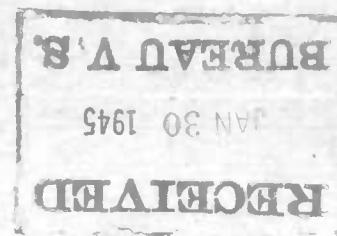
23. SIGNATURE.....

M. D. or other

Henryton, Md.

1/22/45

Date signed



M

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 308

00381

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: Carroll  
County.....  
City or town..... rural near Sykesville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 6 months, 23 days  
Hospital, institution, or street address where death occurred: Springfield State Hospital  
How long in hospital or institution?..... 6 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Garrett  
City or town..... York  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## 3. (a) FULL NAME

Louis Wilt

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) February 18, 1882

6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	Or less than one day
62	11	2	hrs. min.

9. Birthplace..... Garrett County, Maryland  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... Sawmill

12. Name..... York
13. Birthplace.....

14. Maiden name..... York
15. Birthplace.....

16. Informant..... Springfield State Hosp. records
Address..... Sykesville, Maryland

17. Burial.....
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Westerport
Location..... Allegany Co., Md.

18. Funeral director..... D. V. Soul
Address..... Westerport, Md.

19. Date rec'd by registrar..... Jan. 20 1945
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

January 20 1945 at 12:20 P.M.

20. DATE OF DEATH..... November 8 1944 Jan. 20 1945

and that I last saw him alive on January 20 1945

Immediate cause of death General paralysis  
of the insane, prior toDURATION  
May '44

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

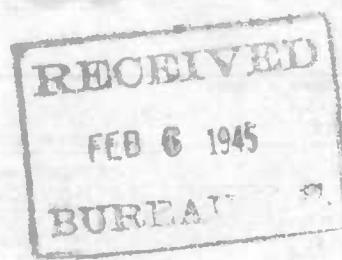
Means of injury..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE..... Robert Bertrand May, M.D.

Springfield State Hospital M.D. or other

Address..... Sykesville, Maryland Date signed..... 1-20-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-2

00382

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 yrs 6 mos 25 days

Hospital, Institution, or street address where death occurred

Springfield State Hospital

How long in hospital or institution?

4 yrs 6 mos 25 days

## 3. (a) FULL NAME

Anna Hisochar

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

J.

W

Widowed

6. (b) Name of husband or wife

Unknown

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

1867

8. AGE: Years

Months

Days

If less than one day

78

"

hrs.

min.

9. Birthplace

(Town, county, and state)

Poland

10. Usual occupation

Unknown

11. Industry or business

Unknown

FATHER

12. Name

Unknown

MOTHER

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Anna Huncher

Address

722 S. Registered Batter

17. Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 20 1945

(month) (day) (year)

Cemetery or crematory

Springfield Cem. Cemetery

Location

Sykesville, Md.

18. Funeral director

C. Harry Lee

Address

Sykesville, Md.

19. Date rec'd by registrar

Jan 20 1945

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Baltimore

M

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1

M

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 13 1945 at 5 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June 17 1940 to Jan 13 1945

and that I last saw her alive on

Jan 13 1945

1945

M

M

M

M

Immediate cause of death

Broncho Pneumonia

DURATION

2 days

Due to

Ch. Arteritis

8

Arteritis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

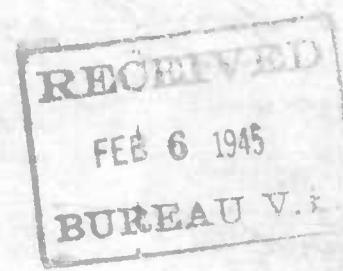
23. SIGNATURE

M. D. or other

Address

Date signed

11/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
percentage  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

00383

## CERTIFICATE OF DEATH

Reg. Dist. No. 76

## 1. PLACE OF DEATH:

County.....Carroll

City or town.....WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....9 HRS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

ALLEN WITMER

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	WHITE	SINGLE

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....JANUARY 4, 1945

8. AGE:	Years	Months	Days	It less than one day
				9 hrs.

9. Birthplace.....WESTMINSTER, MD.

(Town, county, and state)

10. Usual occupation.....

## 11. Industry or business

12. Name.....WILLIAM R. WITMER

13. Birthplace.....HAGERSTOWN, MD.

14. Maiden name.....JEANITA A. VINSION

15. Birthplace.....HAGERSTOWN, MD.

16. Informant.....WILLIAM R. WITMER

Address.....WESTMINSTER, MD.

17. BURIAL.....Date thereof.....1/5/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....WESTMINSTER CEM.

Location....." MD.

18. Funeral director.....J. FRANCIS REESE

Address.....WESTMINSTER, MD.

19. (Date rec'd by registrar) 1/15/45

IS.....*AK* *Alfred K. Klemm*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. or other.....County.....Carroll

City or town.....WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No.....309 E. Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....JANUARY 4 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 4 1945 to January 4 1945  
and that I last saw her alive on January 4 1945.

Immediate cause of death.....

Due to.....Fracture back - broken  
vertebrae - paraparesis -

DURATION

2 hrs.

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....*Shuster Boen* (M.D.)

M. D. or other

Address.....WESTMINSTER, MARYLAND Date signed 1/4/45



•  
3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Original sent to State Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13.

00384

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:  
County Carroll  
City or town Henryton

(If outside city or town limits, write RURAL and give nearest town)  
1 month, 8 days

How long in above place of death? 1 month, 8 days  
Hospital, institution, or street address where death occurred:  
Maryland Tuberculosis Sanatorium  
Colored Branch, Henryton, Md.

How long in hospital or institution?

3. (a) FULL NAME

MYRTLE WRIGHT

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced  
female      colored      married

6. (b) Name of husband or wife      Langdon Wright

7. Birth date of deceased (mo., day, yr.)      8. (c) If alive, give age      years  
October 22, 1917

8. AGE:      Years      Months      Days      If less than one day  
27      2      21      hrs.      min.

9. Birthplace      Ellicott City, Md.  
(Town, county, and state)

10. Usual occupation      Housewife

11. Industry or business

FATHER      12. Name      John Cole  
13. Birthplace      Granite, Maryland

MOTHER      14. Maiden name      Virginia Smith  
15. Birthplace      Cooksville, Md.

16. Informant      Reuben Hoffman, M.D.

Address      Henryton, Maryland

17. Burial      Date thereof      1-12-45  
(Burial, cremation, or removal. Which?)      (month) (day) (year)

Cemetery or crematory      Ellicott City

Location      Ellicott City, Md.

18. Funeral director      J.F. Wigington

Address      Ellicott City, Md.

19. Jan. 12      19. 45      Albert R. Swank  
(Date rec'd by registrar)      M. D. or other

Deputy Registrar  
Deputy Local

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland      County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 928 Harlem Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number  
none

MEDICAL CERTIFICATION

20. DATE OF DEATH      January 12, 1945, at 9:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4, 1944, to Jan. 12, 1945, and that I last saw her alive on January 12, 1945.

Immediate cause of death      Pulmonary Tuberculosis

DURATION  
March 1943

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide      Date of

Where did injury occur?      (City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)

Means of injury

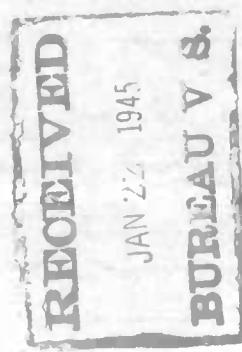
Injured at work?

23. SIGNATURE      Reuben Hoffman, M.D.

M. D. or other

Address      Henryton, Md.

Date signed 1-12-45



M

TRADESMI RESERVEED FOR BINDING

110

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## **CERTIFICATE OF DEATH**

00385

74

Reg. Dist. No. ....

1. PLACE OF DEATH: County.....		Carroll		
City or town.....		Henryton, Md.		
(If outside city or town limits, write RURAL and give nearest town)				
How long in above place of death?		1 month, 22 days		
Hospital, institution, or street address where death occurred: Maryland Colored Branch, Henryton, Md.				
How long in hospital or institution?				
3. (a) FULL NAME <b>THOMAS EUGENE YOUNG</b>				
4. Sex male		5. Color or race colored	6. (a) Single, married, widowed, or divorced single	
6. (b) Name of husband or wife.....				
7. Birth date of deceased (mo., day, yr.) May 9, 1921				
8. AGE:      Years      Months      Days      If less than one day 23      8      2      .....hrs.      .....min.				
9. Birthplace..... (Town, county, and state) Leonardtown, Md.				
10. Usual occupation..... Surveyor's Helper				
11. Industry or business				
FATHER	12. Name..... Eugene Young			
	13. Birthplace Leonardtown, Md.			
MOTHER	14. Maiden name..... Elizabeth Trent			
	15. Birthplace Leonardtown, Md.			
16. Informant..... Reuben Hoffman, Md.				
Address..... Henryton, Maryland				
17. <u>Burial</u> (Burial, cremation, or removal. Which?)		Date thereof..... Jan 15 - 45 (month) (day) (year)		
Cemetery or crematory..... St. Agnes.				
Location..... Leonardtown, Md.				
18. Funeral director..... H. C. Mattingley Sons				
Address..... Leonardtown, Md.				
19. Jan. 11, 1945 (Date rec'd by registrar)		Albert R. Swank Deputy Local Registrar		

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County St. Mary's  
City or town Leonardtown,  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war. ....

3. (b) Social Security Number  
Lost

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 11, 1945 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20, 1944 to Jan. 11, 1945, and that I last saw h. .... alive on Jan. 11, 1945.

Immediate cause of death Pulmonary Tuberculosis DURATION 10-15-44

Due to. ....

Due to. ....

Other conditions. ....

(Include pregnancy within 8 months of death)

Major findings of operations. .... Date of op. ....

Autopsy results. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. .... Date of. ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work? ....

23. SIGNATURE. .... Leuben Hoffman, M.D. M. D. or other  
Address Henryton, Md. Date signed 1-11-45

APPROVED BY THE DEPARTMENT OF STATE  
FOR RELEASE UNDER E.O. 14176

